PRACTICE GUIDELINES FOR SCREENING CHILDREN & ADOLESCENTS FOR SUBSTANCE ABUSE, DEVELOPMENTAL DISABILITY AND MENTAL ILLNESS

A Report Submitted to the Missouri Department of Mental Health
Steering Committee for Practice Guidelines

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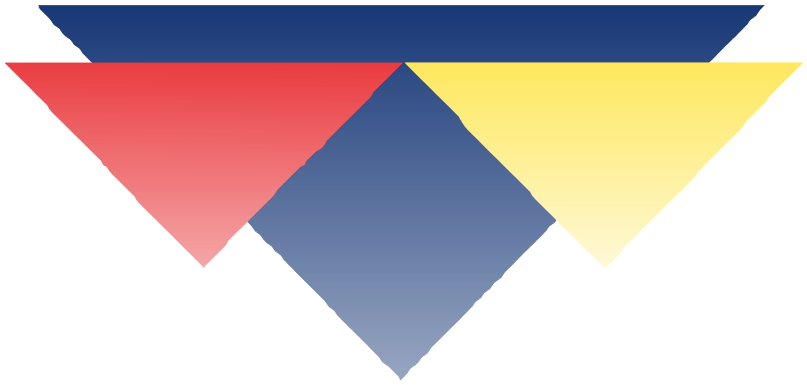
I. EXECUTIVE SUMMARY



The Practice Guidelines Steering Committee provided the following charge to the Team:

The charge is to develop practice guidelines to screen for indicators of substance abuse, developmental disabilities and emotional disturbance for children and youth. These guidelines should be applicable for all service providers, independent of their specific expertise or area of work, that can guide their assessment of children and youth to include broad indicators of deficits and/or needs in the areas of substance abuse, developmental disabilities and emotional functioning as part of a more in-depth assessment in a specific area.

The following should be included/considered:

1. *Knowledge of the proposed system of care for children, youth and families to guide implementation of the screening/assessment process within this system of care.*
2. *Review and recommend various methods of obtaining information (clinical interviews, structured interviews, checklists, computerized assessments, collateral information). The guidelines should be flexible to allow broad application in a variety of situations/settings.*
3. *Consider the timeframe for the screening within the broader assessment and need for screening over different time periods of service.*
4. *Consider guidelines for follow-up based on identification of needs including timeframes dependent upon the urgency of the need.*
5. *Consider need for the screening to be flexible to meet the needs of multiple payor sources.*
6. *Consider qualifications and training of staff that conduct the screenings.*
7. *Consider multiple cultural issues and the respective impact of each. In particular, due to normal developmental issues for children and youth, consider if different guidelines are needed for identified age groups.*
8. *Consider how to make the process consumer friendly. This is particularly true in guiding how assessments across multiple divisions/providers can be more integrated.*

The Screening and Writing Team spent time exploring the meaning of the term screening and the utility of screenings. *It should be noted that the term screening for the purpose of the guidelines is in relation to a clinical screening and not related to screening for eligibility for services.* The Team reviewed the literature and discussed the information at length based on clinical experience. Based on this review and process of consensus building, the following are provided as recommended guidelines.

PROCESS GUIDELINES

- Screenings are brief
- Screenings can be embedded within a related assessment
- Screenings should be developmentally appropriate particularly in the use of the screener's language and knowledge of developmental issues particularly pertaining to the manifestation of symptoms, as well as the significant impact the environment has on a child/youth's functioning
- Screenings should be on-going
- Screening is necessary but not sufficient for service planning
- Screening should include documentation of the outcome
- Screenings should be culturally sensitive and competent
- Screenings should take into account the need for other/multiple sources of information
- Although there are multiple formats that can be utilized, if a formal tool is utilized it should have adequate psychometric properties

- Staff conducting screening as part of an assessment should be qualified as outlined by professional and monitoring agencies as well as payor sources. Within the DMH, based on the respective division's criteria, at a minimum screeners should be a QMHP, QMRP or QSAC

CONTENT GUIDELINES

A. Psychiatric/Emotional – Areas to be assessed

- Poor Peer Relationships
- Deterioration or Change in Adaptive/Regulatory Functioning
- Negative Emotional State
- Risk of Self-Harm
- Risk of Harm to Others
- Somatic Complaints
- Delusions/Hallucinations
- Deficit in Attention Span
- Impulsivity
- Explosive Behavior
- Paranoid/Suspiciousness
- Eating Habits/Body Image

If the child/youth has current thoughts of harm towards himself/herself or others, has access to the means to harm themselves or others, and has no effective means for guaranteeing safety, an emergency referral should be made to a private hospital for admission, or an administrative agent of the Division of CPS or the Access Crisis Intervention (ACI) system for screening for need for admission to a DMH psychiatric unit.

B. Developmental Disabilities

- Is the youth receiving special education services?
- Is there a delay in achievement of developmental milestones?

For Children Ages 0 to 4

A persistent failure to initiate or respond in age appropriate manner to social interactions, such as:

- Absence of visual tracking
- Absence of reciprocal play
- Lack of vocal imitation or playfulness
- Little or no spontaneity
- Lack of or little curiosity and social interest

Having obtained no more than 50% of the developmental milestones regarding:

- Cognitive
- Speech language
- Self-help
- Physical
- Psychosocial

Indicators for all ages

- Language delays
- Difficulty with abstract concepts (beyond what is typical for age)

- Difficulty with fine and gross motor skills
- Physical anomalies - atypical physical development
- Maternal history of alcohol or drug use, particularly during pregnancy
- Limitations in self care
- Limitations in learning
- Limitations in self-direction
- Limitations in capacity for independent living related to age appropriateness
- Limitations in mobility
- Sub-average cognitive functioning accompanied by substantial limitations in adaptive behavior that are expected to last indefinitely

C. Substance Abuse

1. The child/youth answers positively to at least one of the questions.
   AND/OR
2. There are significant risk factors identified

Questions

Frequency/Quantity: How often and how much do you use alcohol… inhalants … illegal drugs…over the counter or prescription drugs?

Recency: When was the last time you were high or drunk?

Future Intent: Do you intend to use alcohol, inhalants or other illegal drugs in the future?

Impairment: Have you ever gotten into trouble because of your use of alcohol, inhalant, other illegal drugs, over the counter medications, or prescription drugs?

Other's perceptions: Has any one ever told you that they were concerned about your use of alcohol, inhalants, other illegal drugs, over the counter medications or prescription drugs?

Additionally, the child/youth should be queried about tobacco use. If a child/youth admits to use of tobacco, as a significant health concern, information should be provided related to health risks and referral to a health care provider.

If a youth is currently intoxicated and is showing some of the following signs, an emergency referral for medical evaluation or emergency detoxification should be considered.

The child/youth is unresponsive, agitated or combative
The child/youth has reported and is responding to hallucinations
The child/youth is or has recently had a seizure
The child/youth appears to have an increased heart rate and a significant change in respiratory rate
The child/youth is reporting a severe headache, chest pain or abdominal pain
Loss of feeling in, or an inability to move, a body part
Nausea or vomiting for greater than 12 hours, or vomiting blood

Risk factors

- Deterioration in functioning
- Legal Involvement/Delinquency
- Parents who abuse alcohol or drugs
- Physical, sexual or psychological abuse
- Dropped out of school
- Teen pregnancy

- Lower income level
- Crime and violence in neighborhood
- Gang activity
- Violent/aggressive behavior
- Suicide attempts or other mental health problems identified
- History of placements in foster homes, homeless shelters or running away

D. Selection of Instruments

A specific screening tool was not identified that screened in all three areas, nor were there many tools that the team felt met criteria for even one area. Although the team is not recommending any one specific tool to be used in an area, the team in its review of screening tools was able to identify some instruments that could be utilized to screen for one specific area. The criteria providers should use to assess the qualities of a specific screening instrument are addressed as well as a brief list of screening tools that met the cited qualities.

RECOMMENDATIONS

The team identified a number of issues that would have to be addressed for effective implementation of a screening procedure for children and youth.

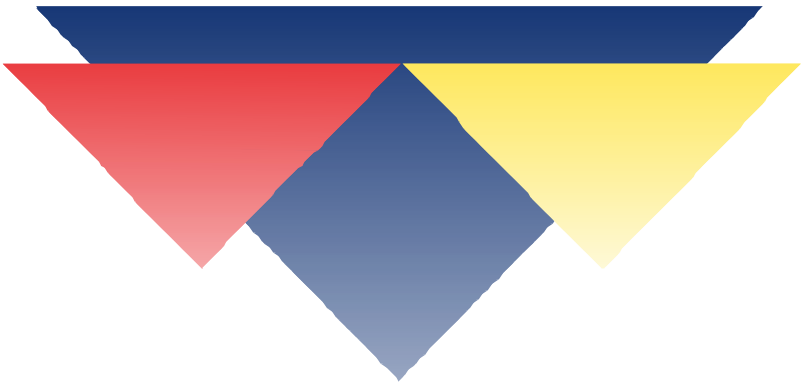
Development of a Common Screening Tool – As noted above, one tool was not identified that effectively screened children/youth in all three areas of psychiatric/emotional disorders, developmental delays, and substance abuse disorders. Included in the document are the procedural and fiscal requirements if such a tool were to be developed specifically to meet this need.

Implementation and Dissemination of Information – This should be given considerable thought prior to moving forward. Issues to be addressed include but are not limited to those cited in the document.

Capacity – Effective screening will increase the number of assessments that are required as well as follow up services/supports. This will impact the available resources through the public mental health system. If capacity issues are not addressed in conjunction with use of increased and better screening mechanisms, it becomes an exercise in futility and frustration.

Training – Training is essential to the effective implementation of global screenings for children and youth. Although minimum qualifications within a system are recommended, this does not guarantee knowledge in other areas or knowledge of system issues. Three critical areas of training include: cross-training on specific conditions, global training on developmental issues and cross-training on system issues. Development of a manual is recommended to provide continuity across agencies and time.

II. INTRODUCTION



A. DEFINING THE ISSUE

Practice Guidelines are parameters designed to improve the quality of care for a specific procedure or population. These guidelines are typically achieved through informed consensus and rely on empirical evidence when available. The Missouri Department of Mental Health has chosen to develop Practice Guidelines in five areas:

- Children's Medications
- Screening and Assessment
- Co-Occurring Disorders: Developmental Disorders/Mental Illness
- Co-Occurring Disorders: Mental Illness/Substance Abuse
- Self-Determination/Recovery

This paper outlines the initial phase of work done by the Screening and Assessment Writing Team (henceforth known as the Team).

The Team spent considerable time identifying the problems and limitations with screening and assessments as currently practiced, as well as differentiating the two processes. Ideally, Practice Guidelines should help alleviate some of the problems and reduce the limitations. The Team identified the following issues:

- High rates of co-morbidity
- Specific issues related to children's diagnoses (i.e., reliability)
- Disparity between screening/assessment and philosophy of a system of care
- Timeliness of screenings and/or assessments
- Reliability of information obtained
- Staff competencies to conduct screening/assessments

Additionally, the Team felt it must carefully delineate the purposes of screening and assessments. It would appear that the term "screening" has many meanings depending upon the context. In some cases, screening is meant to determine eligibility for services. This can be based both on clinical and non-clinical information. For example, it might be based on financial need, geographic location, individual characteristics such as age, race, or military status, type of problem or severity of problem.

The process of clinical screening is deemed an "alerting" function. It is the first step in identifying potential psychiatric/emotional, developmental or substance abuse problems, and would lead to a decision to further assess or not. Screening is not meant to result in a diagnosis nor to provide information for long-term treatment planning, but rather to alert the professional that further assessment may be necessary. Also, it should inform the screener to whom a referral should be made for further assessment. Screening, as used in this paper, references clinical screening to determine whether there are indicators of the presence of a mental health condition/disorder/problem. Based on the outcome, the screener may need to make a determination to whom a referral should be made based on their knowledge of eligibility criteria. Eligibility is NOT the focus of this paper, although it will be addressed briefly later.

Assessments are meant to provide a more in-depth and comprehensive examination and should result in both a diagnostic conceptualization and an initial treatment/service plan. An assessment should result in at least a provisional opinion as to the presence of a disorder/condition that requires intervention. It should also guide implementation of the initial interventions.

Screenings and assessments fall on a continuum depending on the who is conducting the screening/assessment and the outcome of the screening or assessment. The Team developed the following continuum on screening/assessment:

- Public Awareness of crucial Behavioral Health warning signs or risk indicators
- Community Screening used by natural community resources that may come into contact with high risk or priority populations
- Behavioral Health screening conducted by behavioral health staff to determine clinical need and/or eligibility
- General Assessments to aid in treatment/service planning
- Specialized Assessments to focus on a specific issue/disorder/risk

The Team debated the impact of prioritizing development of practice guidelines at these critical points. At the request of the Practice Guidelines Steering Committee, the Team agreed to focus on behavioral health screenings conducted within the behavioral health field (third dotpoint above). However, the Team recognized the critical importance and significant impact of educating the public on risks and warning signs and assisting natural community systems that come into contact with the identified population in identifying individuals who may be at risk. The Team supported the idea that the Dept. of Mental Health, as the mental health authority for the state of Missouri, should address these issues.

The Practice Guidelines Steering Committee provided the following charge to the Team:

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The Team then outlined the utility of clinical screening. Ford (1988) applied the World Health Organization (WHO) criteria for evaluating the utility of general medical screening tests to psychiatric screening procedures. Specifically these criteria are:

1. The condition must have a significant effect on the quality or quantity of life;
2. The incidence of the condition must be sufficient to justify the cost of screening;
3. The condition must have an asymptomatic period during which detection and treatment significantly reduce morbidity or mortality;
4. Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delayed treatment until symptoms appear;
5. Acceptable methods of treatment must be available:
6. Tests that are acceptable to patients must be available at reasonable cost to detect the condition in the asymptomatic period.

Based on diagnostic criteria for almost all disorders, it appears obvious that psychiatric, developmental and substance abuse disorders have a significant impact on the quality of life. In the Surgeon General's Report on Children's Mental Health, it is estimated that 11% of children in the U.S. ages 9 to 17 have a diagnosable or addictive disorder associated with significant functional impairment. This increases to 21% if the standard is minimal impairment. Five percent are felt to have extreme impairment. As this translates to approximately 4 million children in the United States with significant impairment, the prevalence and impact of such disorders supports the need for effective and timely screening for psychiatric, substance abuse and developmental disorders.

Screening for mental illness/emotional disturbance, developmental delays and substance abuse within the mental health system is also critical because of the high rate of co-morbidity across these issues. For example, Kanwischer and Hundley (1990) found that 75% of the youth at a midwestern public mental health hospital had an additional substance abuse disorder. Other studies have found as high as 80% of individuals in substance abuse treatment have a lifetime rate of a co-occurring mental disorder (Kessler et al, 1996; Ross et al, 1988; Mirin et al, 1988). Previously, the Department of Mental Health did propose a common screening tool to be used to identify psychiatric and substance abuse issues in adults (Appendix I) that was incorporated by some providers. The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (APA, 1994) cites that "individuals with Mental Retardation have a prevalence of comorbid mental disorders that is estimated to be three to four times greater than in the general population". Providing screenings for other concerns during an assessment can also aid in providing differential diagnoses. For example, is substance abuse masking an underlying depression? Additionally, due to high prevalence rates, screening all youth for certain concerns has been presented as an appropriate health care response (Elster &Kuznets, 1994; Glascoe, 1991). Unfortunately, current practice does not seem to typically involve even minimal screening for co-morbid disorders (see Appendix II).

As Ford (1988) points out "… in psychiatric diseases, it is difficult to know what asymptomatic means, as there are currently no reliable laboratory or pathologic tests to confirm diagnoses. The presence of the symptoms is the only way to make a diagnosis". However Ford goes on to note identification of known risk factors may be part of the "asymptomatic" stage with psychiatric disorders. Screening youth for a co-morbid disorder during an assessment would be appropriate given the high prevalence of co-occurring disorders. In the field of mental health, there is sufficient evidence that prevention and early identification can have an impact on development or impact of a disorder. This

is particularly true for children and youth and for more serious disorders. Although valid arguments can be made that there has not been enough research directed towards evidenced-based practice in child and adolescent mental health services, there is a growing body of knowledge about what is effective with children/youth (Hoagwood et al. 2001). The Team supported the direction of resources to research designed to examine the efficacy of treatment in various community settings.

B. IMPACT OF SCREENING AND ASSESSMENT GUIDELINES ON A SYSTEM OF CARE FOR CHILDREN, YOUTH AND FAMILIES

Early identification of mental health concerns has been shown to increase the probability for a positive outcome and/or to limit the debilitating effects of a serious condition. This underlines the need not only for effective screenings but the importance of educating the public on warning signs/risk factors of mental and substance abuse disorders and developmental conditions. At the request of the Department of Mental Health, the Team agreed to focus on development of common content areas for screening children and youth. This would aid in the implementation of the System of Care for Children, Youth and Families.

It is noted within the "**System of Care for Children, Youth and Families"** a DMH report, *"A system of care is a comprehensive array of mental health and other necessary services which are organized in a coordinated way to meet the multiple and changing needs of children, youth and their families. However, a system of care is more than an array of services, it is a philosophy about the way in which children, youth and families receive services. Partnerships at all levels between families, providers, communities, regions and the state are fundamental to an effective system of care".* This paper goes on to state that *"Many of the youth that present challenges to the community and our systems are youth experiencing co-occurring disorders. These youth and their families may be shuffled between agencies, often dropping out of services due to frustration and "lack of ownership". Within the Dept. of Mental Health, the model must direct the appropriate mechanisms for youth/families to access services across Division lines and implementation of a single collaborative plan for delivery of services".* Obviously to achieve this goal, the first step would be to identify those youth who present with a co-occurring disorder. To this end it is stated that one of the primary functions that should occur is *"…an initial screen for psychiatric, developmental or substance abuse problems/needs that may prompt the need for connection to other Department divisions for more in-depth specific assessments".* This document and related protocols outline the specific steps for the process of coordinating assessments and treatment. Therefore the focus of the Team was on the content and general process of actually conducting the screenings.

Identification of specific syndromes/disorders in children and youth is particularly difficult due to the impact of developmental issues. Children/youth are constantly changing as part of their normal development. As noted in the Surgeon General's report on mental health "diagnosis and diagnostic classifications present a greater challenge with children than with adults". It is noted that this is due to several reasons:

> *"Children are often unable to verbalize thoughts and feelings…Children's normal development presents an ever-changing backdrop that complicates clinical presentation…Finally, the criteria for diagnosing most mental disorders in children are derived from those for adult even though relatively little research attention has been paid to the validity of these criteria in children".*

As screening is the first step towards developing a diagnostic picture, these issues are equally important. Since so many "diagnostic" symptoms may be "normal" behaviors in children, the

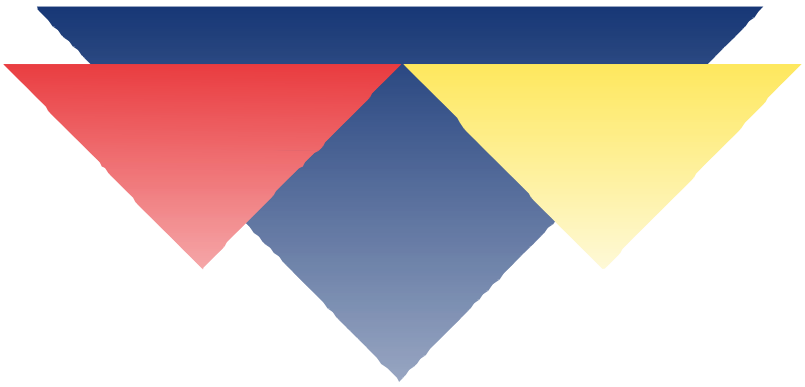
clinician must be cognizant of developmental issues and determine if the frequency or intensity of a symptom in not congruent with normal development. However, since screening is designed only to identify children/youth with "risk factors", the process of referring on for a more thorough assessment can allow for more accurate identification of syndromes/disorders. It was felt that in the balance between over-identification and under-identification within the screening process, the former was the preference.

To aid in providing a full continuum within a System of Care for Children, Youth and Families, a focus on the screening of children and youth supports the concept of early identification. Early identification of a youth with a substance abuse problem, rather than waiting until his/her third DWI or losing a job as an adult or experiencing failed interpersonal relationships, decreases the cost to the individual as well as to society. Although many serious mental illnesses do not fully manifest until late adolescence or early adulthood, there can be indicators or precursors within childhood or early adolescence. Research has shown that early intervention can reduce the long-term and often devastating impact of such serious psychiatric disorders. The level of plasticity in youth also increases the likelihood that interventions may be more effective and have a positive long-term impact.

A review of the literature was conducted (see Appendix III) with the assistance of the Missouri Institute of Mental Health Library. Key words to guide the initial search included "assessment" and "epidemiological" combined with the three clinical areas of child mental health, developmental disabilities and substance abuse. Due to the initial interest of the group and the focus on screening, "behavioral health vital signs", "public awareness campaigns" and "practice parameters" were also key phrases provided in a search of the literature. Initial literature searches were forwarded to all team members to identify those resources that were felt to be pertinent to the task. Once these resources were identified, copies of the articles/chapters were obtained and sent to two to three members of the Writing Team for review. Ideally, one specialist, one non-specialist (a "specialist" was someone who practiced in the designated area of psychiatric, substance abuse or developmental disabilities) and a consumer/parent were to review each article and provide feedback to the Writing Team. Although practice parameters for the clinical assessment of specific disorders in children and youth exists, very few studies have been reported on the screening of children/youth for psychiatric or substance abuse disorder or developmental conditions. The Team therefore reviewed the 'diagnostic specific' articles and attempted to pull out process issues related to screening children and youth, as well as to identify general content areas to be included in an initial screening tool.

Based on the above literature review, it was determined that identification of common content areas in all threes areas (psychiatric, developmental and substance abuse) to use in screening children and youth would currently have the most impact on the system. In this way, all children and youth who come into contact with a provider in one area can be screened for needs related to the other two areas. The process for coordinating assessments and service planning is being developed within a protocol for the System of Care for Children, Youth and Families. Thus this paper provides the guidelines for the process of screenings and content areas/indicators across the three areas.

III. PRACTICE GUIDELINES FOR SCREENING CHILDREN AND YOUTH FOR EMOTIONAL DISTURBANCE, DEVELOPMENTAL DELAYS AND/OR SUBSTANCE ABUSE



A. PROCESS GUIDELINES

The following are guidelines for an effective screening process.

Screenings are brief - Screenings are the first step in a hierarchy of the assessment process. Screenings are not meant to provide a diagnosis or to be used in development of long-term service plans. Thus, screenings are only designed to determine if a more complete assessment is needed. The costs of conducting the screening (both time and convenience of the consumer and screener as well as financial considerations) should be weighed against the benefits. Due to the limited goals of screening, a screening should be able to be conducted in a brief amount of time with minimal fiscal or temporal costs. (Bastiaens et al, 2000; Kanwischer, 2001; Kenny & Culbertson, 1993; Knight et al. 2002)

Screenings can be embedded within a related assessment – In the context of this document, screenings are referred to as being conducted in two of three areas when the child/youth is being fully assessed in the third area. The process of screening can occur as a separate discrete process or as part of the initial and on-going assessment process within an area. Consideration should be given to the overlapping indicators for children and youth with a psychiatric, developmental or substance abuse disorder and redundancy should be minimized. (Group consensus based on current practice)

Screenings should be developmentally appropriate – The population of children/youth encompasses individuals from birth up to 18 years of age. Specific developmental issues exist within this age range. Screenings should be appropriate to the age of the individual being screened. (AACAP, 1997)

Language - Some of the issues related to language use and comprehension include but are not limited to the following guidelines for the screener:

- Use simple words (do not assume because a child uses a word that the child understands the meaning of the word)
- Use one thought per question/statement
- Validate youth's understanding of temporal contexts (when an event occurred)
- Use of concrete terms rather than abstract terms
- Validate youth's understanding of comparative or relational terms (before/after, older/younger, bigger/smaller)
- Limit use of clinical jargon
- Addressing issues of primary language (English as a second language)

(Walker, 1999)

Manifestation of Clinical Symptoms – Research focusing on the etiology, prevention and intervention of psychological disorders in children and youth has not received equal attention to that of adult disorders (Fisher et al. 1999; Hoagwood et al, 2001; Kazdin, 1993; Surgeon General's Report, 1999). Presuming diagnostic categories established for adults generalize directly to children will lead to errors in decision-making. In conducting a screening to identify potential symptoms of a psychiatric, developmental or substance abuse disorder, unusual manifestation of symptoms in children and youth should be considered. Some examples of these manifestations include:

- Presence of irritable mood in an affective disorder
- Shorter duration of irritability/depressed mood in diagnosis of Dysthymic Disorder

- In diagnosis of Post Traumatic Stress Disorder:
  - Distressing dreams may not have recognizable content for children
  - Repetitive themes or aspects of trauma may be manifested as opposed to recurrent or intrusive thoughts
  - Expression of trauma through repetitive play
- Expression of impairment in an Autistic Disorder
- Expression of anxiety and/or fears in children
- Manifestation of delirium in children

(AACAP, 1997; Fisher et al, 1999; Hoagwood, et al., 2001, Report of the Surgeon General, 1999; Roberts et al, 1989)

Impact of Environment and Development - Children and youth are more likely to be impacted by their environment due to their limitations in control/influence over it and more susceptible to both the positive and negative influences of the environment (Glascoe, 1991). These issues should be examined if and when potential problems are identified. Additionally, impact of developmental transitions on a child/youth's presentation of symptoms must also be taken into account. (AACAP, 1997; Aylward, 1990; Fisher et al, 1999; Glascoe, 1991; Hoagwood et al, 2001; Knight et al, 2002; Sameroff, 1975)

Screeners should have some knowledge of normal developmental processes as well as "Disorders First Usually Diagnosed in Infancy, Childhood or Adolescence" with the DSM-IV.

Screening should be ongoing – Children and youth continually present with emerging developmental issues. Their response to environmental demands during development constantly changes. Therefore, a child/youth should be screened at intervals for the development of indicators of psychiatric, developmental and substance abuse disorders.

At times of stress, practitioners should be especially cognizant of emerging indicators. Such times may include but not be limited to experiencing divorce or other losses, exposure to domestic or other forms of violence, changes in school or living arrangements, involvement with the juvenile justice/legal system, and/or experiencing a significant emotional or physical trauma. Youth may also have a delayed onset of symptoms due to developmental issues. For example a youth, sexually abused as an infant, may have an exacerbation of symptoms upon achieving puberty. Additionally, when screening for developmental delays, specific functions develop at different times. Therefore early screening of a three year old child, may not identify a language delay, either because of limitations in language development or the insensitivity of the screening instrument. If no further screening was done, it could be assumed that no delays exist. However, if a child was screened again at the age of four years, using the same screening tool, a language deficit might be identified.

In the preschool years screening should be done annually. After that, a screening might be re-done when a youth experiences a stressor. The clinician should be cognizant of newly developing symptoms and the efficacy of on-going interventions. (Glascoe, 1991; Kanwischer, 2001; Kenny & Culbertson, 1993; Meisels & Wasik, 1990; Sameroff, 1975)

Screening is necessary but not sufficient for service planning – Although screening is the first step in a hierarchy of assessment processes required for long-term service planning, it is not sufficient to plan beyond the immediate needs of a child/youth. After conducting a

screening, a child/youth determined to be at imminent risk for harm to self or others (or presenting in a medical crisis), should be immediately referred for an emergency assessment and/or crisis intervention. (Kanwischer, 2001; Kenny & Culbertson, 1993)

Screening includes documentation of outcome – The screening process should lead to an initial conceptualization of the presence or absence of a psychiatric, developmental or substance abuse disorder. (Ford, 1988 and Group Consensus) This conceptualization should be documented along with action steps, if any, that were taken. Options for action steps include, but are not limited to:

1. Screening is negative in all areas, no action needed at this time.
2. Screening is positive for potential "condition" outside of provider's typical area of service provision, further assessment is done by that provider and services/supports for needs related to the condition are incorporated into the provider's service plan.
3. Screening results in a positive finding for a potential "condition". Child/youth and their guardian are assisted by initial provider in obtaining an assessment from a private community provider who specializes in the "condition" and provides follow up after the assessment in coordinating service planning.
4. Screening results in a positive finding for a "condition". Child/youth and their guardian are assisted by screening provider in obtaining an assessment from a DMH provider that typically specializes in the "condition", obtains necessary consents to share information with that provider, participates in the assessment process with the child/youth and family with that provider as resources permit, and develops a coordinated service plan with the provider.
5. If a youth is referred for further assessment to a DMH provider or a non-DMH provider, the screening provider should follow-up with the assessing provider and/or child/youth and the parent/guardian to determine if a disorder/need was identified. If the result of the assessment was "negative" and the assessing provider will provide no further services, the screening provider should document this.

Screenings are culturally sensitive and competent – In addition to being cognizant of the youth's developmental level in conducting the screening, the screener and process used for screening should be cognizant and respectful of other cultural factors. This includes but is not limited to gender, race, ethnicity, and living situation/location. The screening process should allow flexibility in the formulation of questions that address cultural issues. Additionally, results of the screening process should be reviewed in the context of cultural issues. Screeners should always be cognizant of their own social biases and of the cultural dimensions of the child's life without application of stereotypes. If a specific screening tool is utilized, in addition to acceptable psychometric properties, several normative populations should be examined (AACAP, 1997; Fisher et al, 1999).

Sources of information - Due to the legal status of youth/minors, in most cases the legal guardian will need to consent to the screening. Information from the primary caretaker should be incorporated into the screening process whenever possible. This can be accomplished through completion of a checklist or through an interview process. The need to obtain this information should be balanced with the need for focus and brevity. Assessments that are much more comprehensive are more typically designed to incorporate multiple sources of information. In general, the younger the child/youth the greater the reliance placed on information obtained from the caregiver. Information

obtained from multiple sources can be contradictory at times. The basis for this lack of concordance should be considered (poor reliability of instrument, reliability of informants, type of symptom being assessed, actual variability in manifestation of symptoms in different environments). (AACAP, 1997; Bastiaens et al, 2000; Cantwell et al., 1997; Daugherty & Shapiro, 1994; Kenny & Culbertson, 1993; Robert et al, 1989)

Format of Screening – Multiple formats can be used in conducting a screening including interviews, checklists, parent reports, and self-report instruments. Each format has advantages and disadvantages. For example, parental reports reduce the professional administration time, however, issues include parents' accuracy in reporting, biases, reading level and parents' understanding of the concepts presented (Kenny & Culbertson, 1993). If a specific tool is used to conduct the screening, in addition to acceptable psychometric properties, normative studies should have been completed with children and adolescents in the age range for identified use. Providers should be cognizant of temporal, fiscal, developmental and specificity advantages and disadvantages when selecting a screening instrument. (AACAP, 1997; Babor et al, 1989; Kenny & Culbertson, 1993; Kobak et al. 1996; Miller et al. 1990; Reiss, 1993; Roberts et al, 1989)

Qualification of Screeners – Individuals conducting a screening that is embedded within another assessment process shall be qualified providers as outlined by professional and monitoring agencies, as well as payor sources. Within the Department of Mental Health, this would require screenings to be conducted by Qualified Mental Health Professionals, Qualified Mental Retardation Professionals, or Qualified Substance Abuse Professionals. (See Appendix IV for definitions) It is crucial that the individual have expertise in working with children and adolescents in their knowledge of developmental issues and disorders of childhood/adolescence. If a formal structured screening is conducted utilizing a specific tool, the user should be familiar and comply with the qualifications outlined in that screening tool's manual. If a screening is completed as a separate, discrete process from the assessment, the screener should be trained in, and knowledgeable of, childhood developmental issues, and be supervised by a qualified clinician.

B. CONTENT GUIDELINES

The following information outlines content areas for screening for psychiatric/emotional, developmental and substance disorders. Any tool or format utilized should, at a minimum, contain the following content areas. Within the content areas specific examples are provided to guide the screener in assessing an area. Although these specific questions are not required, the screening format/tool used by a provider should attempt to accurately assess each content area. It should be noted that due to the three general areas being screened through different mechanisms the format of the content areas is slightly different. Additionally, wording of any queries will depend on the age of the informant and whether information is obtained from the child/youth or a different informant.

These content areas were selected based on a review of validated assessment tools in each of the areas and screening tools when available, as well as a review of current practice in the field. The team obtained consensus in selecting the content areas by discussion related to prevalence of problem, impact on functioning and relationship to major disorders affecting children/youth

Psychiatric/Emotional Disorders

The following are content areas that should be assessed as part of the screening. Examples of questions that may be used to obtain information are provided. Information gleaned from these areas should be considered in the context of whether a child/youth might be using alcohol or other substances.

1. Poor Peer Relationships

   Do you have any close friends?
   Are most of your friends your age…older…younger?
   Do you spend a lot of time by yourself?
   Do you get in trouble for fighting at school?

2. Deterioration or change in adaptive/regulatory functioning

   Have you had trouble falling asleep or staying asleep?
   Have you recently lost or gained a lot of weight?

3. Emotional

   Do you often feel unhappy or sad?
   Do you cry a lot or easily?
   Do you feel you have a lot of worries?

4. Suicide Risk or Risk of Self-Harm

   Have you ever thought about hurting yourself? Are you currently having thoughts of hurting yourself?
   Have you ever tried to hurt yourself?
   Have you ever wished you were dead? Do you currently feel like you wish you were dead?

   ****If a child/youth admits to current thoughts about hurting themselves, the screener should ask the following questions:**

   How have you thought about hurting yourself?
   Would you be able to get the items needed to complete this plan?
   What has prevented you from hurting yourself up to now?

   If the child/youth has current thoughts of harm, has access to the means to harm themselves and has no effective means for guaranteeing their safety, an emergency referral should be made to a private hospital for admission, or an administrative agent of the Division of CPS or the Access Crisis Intervention (ACI) system for screening for need for admission to a DMH psychiatric unit.

5. Risk of Harm to Others

   Have you ever thought about hurting someone else? Do you currently have thoughts about hurting someone else?
   Have you ever tried to hurt someone else?

**If the child/youth has current thoughts of harming someone else, ask the following questions:

Who have you thought about hurting? Do you ever see this person?
How have you thought about hurting this person?
Do you have the means to hurt this person?
What has prevented you from hurting this person up to now?

If the child/youth has current thoughts of harm to someone else, has access to the means to harm someone else, and no effective means for guaranteeing the other person's safety an emergency referral should be made to a private hospital for admission or to an administrative agent of the Division of CPS for screening for need for admission to a DMH psychiatric unit. Additionally, and particularly if the child/youth is not hospitalized and has access to a specific individual to whom they wish to do harm, the screener may have a legal obligation to inform the individual to whom harm is being considered and/or the police.

6. Somatic Complaints

   Do you get a lot of headaches?
   Do you feel sick a lot?

7. Presence of Delusions/Hallucinations

   Have you seen things that other people say are not there?
   Have you heard voices that others cannot hear?
   Is there someone trying to control your thoughts, feelings or behaviors?

8. Deficit in Attention Span

   Do you have trouble paying attention at school?
   Do you forget things a lot?
   Do you have trouble finishing things you start?

9. Excessive Impulsivity

   Do you often regret things you have done?
   Do you often do things without thinking? Do people tell you they think you are impulsive or don't stop and think?
   Do you have a lot of accidents?

10. Explosive Behavior Out of Proportion to Environmental Stimuli

    Do you get mad easily? Do you get mad frequently?
    Do you often do things when you are mad that you regret later?
    Have you ever been suspended from school?
    Have you ever been involved with the juvenile office?

11. Paranoid/Suspiciousness

    Do you feel others often talk about you behind your back?
    Do you feel that most people can be trusted?
    Do you think there are people out to get you?

12. Eating Habits/Body Image

    Are you frequently trying to lose weight?
    How would you describe your body/weight?
    Do you frequently throw up after you have eaten?

Developmental Disabilities

1. Is the youth receiving special education services?
2. Is there a delay in achievement of developmental milestones?

For Children Ages 0 to 4

A persistent failure to initiate or respond in age appropriate manner to social interactions, such as:

- Absence of visual tracking
- Absence of reciprocal play
- Lack of vocal imitation or playfulness
- Little or no spontaneity
- Lack of or little curiosity and social interest

Having obtained no more than 50% of the developmental milestones regarding:

- Cognitive
- Speech language
- Self-help
- Physical
- Psychosocial

Indicators for all ages

- Language delays
- Difficulty with abstract concepts (beyond what is typical for age)
- Difficulty with fine and gross motor skills
- Physical anomalies - atypical physical development
- Maternal history of alcohol or drug use, particularly during pregnancy
- Limitations in self care
- Limitations in learning
- Limitations in self-direction
- Limitations in capacity for independent living related to age appropriateness
- Limitations in mobility
- Sub-average cognitive functioning accompanied by substantial limitations in adaptive behavior that are expected to last indefinitely

Developmental Expectations

Listed below are examples of developmental milestones that can be used to guide the screening for developmental delays:

2 years old
Does/did the child . . .
- use a spoon for eating?
- walk well without falling?
- put two or more words together meaningfully?
- show a desire to please you?
- do as told without excessive protesting?

5 years old
Does/did the child. . .
- use a fork when eating?
- run and climb eagerly?
- draw recognizable pictures?
- know colors, shapes, and alphabet?
- play with other children cooperatively?
- wait his/her turn patiently?

8 years old
Does/did the child . . .
- dress and bathe without oversight?
- ride a bicycle?
- read simple stories?
- complete assigned chores on a regular basis?
- follow time limits and restrictions set by caregiver?
- tell time and date?

12 years old
Does/did the child . . .
- do age level school work?
- have the physical ability to be in strenuous activities?
- summarize the story of a TV program or movie?
- exhibit appropriate manners?
- control anger or hurt feelings when denied own way?
- save money for a purchase?

16 years old
Does/did the youth . . .
- attend school regularly?
- do at least one physical activity per day, if possible?
- talk appropriately/respectfully to adults?
- prepare simple meals?
- respond appropriately when reprimanded?
- notify caregiver of whereabouts or schedule?
- earn money outside of allowance?

Substance Abuse

1. Youth's responses to the questions/content areas below reflect potential abuse.
   AND/OR
2. There are multiple significant risk factors identified

Content Area/Sample Questions

Frequency/Quantity: How often and how much do you use alcohol… inhalants … illegal drugs…over the counter or prescription drugs?

Recency: When was the last time you were high or drunk?

Future Intent: Do you intend to use alcohol, inhalants or other illegal drugs in the future?

Impairment: Have you ever gotten into trouble because of your use of alcohol, inhalant, other illegal drugs, over the counter medications, or prescription drugs?

Other's perceptions: Has any one ever told you that they were concerned about your use of alcohol, inhalants, other illegal drugs, over the counter medications or prescription drugs?

If a youth is currently intoxicated and is showing some of the following signs, an emergency referral for medical evaluation or emergency detoxification should be considered.

The child/youth is unresponsive, agitated or combative
The child/youth has reported and is responding to hallucinations
The child/youth is or has recently had a seizure
The child/youth appears to have an increased heart rate and a significant change
in respiratory rate
The child/youth is reporting a severe headache, chest pain or abdominal pain
Loss of feeling in, or an inability to move, a body part
Nausea or vomiting for greater than 12 hours, or vomiting blood

Risk factors

Deterioration in functioning
Legal Involvement/Delinquency
Parents who abuse alcohol or drugs
Physical, sexual or psychological abuse
Dropped out of school
Teen pregnancy
Lower income level
Crime and violence in neighborhood
Gang activity
Violent/aggressive behavior
Suicide attempts or other mental health problems identified
History of placements in foster homes, homeless shelters or running away

Additionally, the child/youth should be queried about tobacco use. If a child/youth admits to use of tobacco, as a significant health concern, information should be provided related to health risks and referral to a health care provider.

C. SELECTION OF INSTRUMENTS

If a provider selects a specific screening tool developed for one specific area, consideration should be given to the advantages and disadvantages of different formats when applying the tools within their agency. All providers should examine screening tools for acceptable psychometric properties at their own site. Reliability of an instrument both over time and across examiners is important. Additionally, different types of validity should be reviewed for an instrument. This includes concurrent validity (the test has been validated against known or actual measures of the outcome, in this case perhaps a diagnostic assessment tool); content validity (the tool's content is meaningful to the outcome); and criterion or predictive validity (the tool's ability to predict the ultimate outcome, in this case the need for services/intervention).

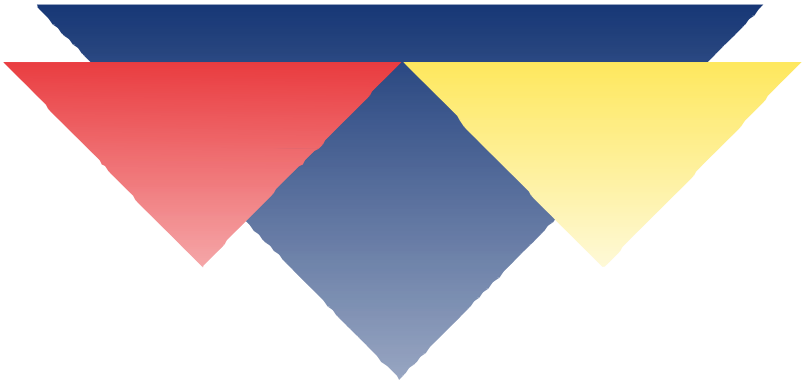
Sensitivity is defined as an instrument's ability to identify a problem/deficit when a problem/deficit actually exists. Instruments with high sensitivity are the most accurate in detecting actual problems/deficits that should be referred for further assessment. Specificity refers to an instrument's ability to identify a lack of a problem/deficit when no problem exists. A good screening instrument would ideally have high specificity as well as sensitivity to avoid referring children/youth for further assessment when it is not needed. However, early in the screening and assessment process, sensitivity is usually preferred over specificity. It is the Team's opinion that it is better to err in making a referral for further assessment on a child/youth who actually does not have a problem/deficit, than to not refer a child for further assessment who needs interventions due to a psychiatric/emotional, developmental or substance abuse disorder.

Additionally, the normative populations used to determine norms or cut-offs for the screening instrument should mirror the population for which the tool will be used as much as possible. This may include gender, age, socioeconomic, geographic, ethnic, racial, and other demographic and personal characteristics of the population.

Through the literature review, a number of instruments were reviewed (see IV and V). These instruments were reviewed in relation to the above criteria. The Team offers the following screening tools as acceptable in its psychometric properties including sensitivity and specificity. However, the Team does not recommend at this time, any one instrument for use. Unfortunately, no single instrument has shown to be globally useful for screening across all three areas. Rather, these instruments have been shown to be specific for one area or even for one disorder.

Psychiatric/Emotional	Strengths and Difficulties Questionnaire Stony Brook Child Psychiatric Checklist Negative Affect Self-Statement Questionnaire Positive and Negative Syndrome Scale for Youth
Developmental Disabilities	Autism Behavior Checklist Checklist for Autism in Toddlers
Substance Abuse	The Teen Addiction Severity Index Personal Experience Screening Questionnaire

IV. ISSUES RECOMMENDED FOR FURTHER CONSIDERATION



Development of a Common Screening Tool

The Team explored the issue of use of a common screening tool across all three division providers. Through a review of the literature, no brief screening tool was identified that screened for psychiatric/emotional, developmental and substance abuse risk factors. Obviously there were many screening instruments that examined one area and even screened for the presence of specific disorders, however, the Team did not feel that this would meet the charge. However, there were few instruments in individual areas that had been demonstrated to have adequate reliability and validity. Many were also actually full assessments rather than screening tools to be used in actual practice. Neither did the Team feel that we could recommend the use of one screening tool for each area, rather as noted above, we provided a list of possible tools that providers may wish to consider. Within the timeframes provided by the Steering Committee and that would meet the immediate needs of the System of Care for Children, Youth and Families, the Team did not feel that we could properly develop **AND** validate a common screening tool. However, included in this document is an outline of the proposed issues, procedures and costs if development of such a tool is considered.

Members of the team supported the need for a single brief screening instrument that could help providers quickly and easily determine if a child should be referred for further assessment in individual or multiple areas. A screening instrument of this kind need only help a provider decide if a problem exists that is serious enough to do a full assessment. Therefore, it should not be a full evaluation itself. The instrument must also be brief, cost-effective, and result in few false positives (resulting in unnecessary costly referrals and evaluations), and few false negatives (resulting in individuals who need treatment and evaluation not being referred). Finally, the committee noted that, if multiple sectors in Missouri use the same screening instrument, data could be coordinated across divisions of the Dept. of Mental Health and a comparative profile of the population of each division could be obtained.

To develop a screening instrument, one must first decide on the areas to be screened. Based on the current structure for the administration of mental health services in the State of Missouri, the Team suggested the areas to be psychiatric, substance abuse, and developmental disability. Also, there should be different versions of the instrument that are appropriate for different age groups to be pertinent to developmental needs. Finally, the instruments must also be designed so that available mental health personnel can complete it. Information may need to be obtained from the identified client, but also from caretakers and interested persons. These sources of information are likely to vary by the age of the child/youth and problem area.

Since there seems to be no one instrument that serves the screening needs of the state of Missouri, one must be developed. The development of this instrument should be derived from a careful review of extant instruments for reliability and validity and practicality. The best instruments or sections of extant instruments that tap the areas may be selected as models or for direct inclusion in the screening instrument. The ideal screening instrument should suit the age of child, disorder area, and constraints of the respondents. Understanding and acceptance must be obtained from the many stakeholders within the community who agree that such a screening instrument would be useful and applicable and would identify the children in need of services. Appendix VII contains an example of a design and budget of a validation study.

Implementation and Dissemination of Information

Corrigan et al. (2001) explore many of the barriers to implementation of evidenced-based practices including existing state law, administrative policies, funding priorities, advocates' concerns and program staffing. Although some specific issues are identified below, it is strongly recommended that in implementation of any of these practices realistic assessment of the above-cited barriers be conducted.

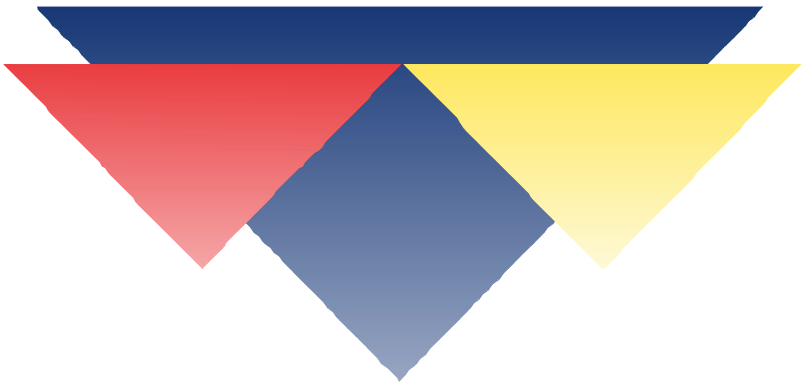
Capacity

Although the team embraced the concept of promoting better screening and assessment of children and youth, the goal of such improvements would be earlier and more frequent identification of children and youth in need of some level of service/support due to a psychiatric/emotional, developmental or substance abuse disorder. As professionals in the field, this is no doubt a goal for which to strive. However, with the fiscal restraints placed on providers of the MO Department of Mental Health, capacity to serve those children and youth currently identified is strained at best. Currently, divisions of the Department of Mental Health can serve only 10 to 50% of children/youth eligible for services. Although the guidelines provided in this report are not limited specifically to public providers of service, this will undoubtedly increase the number of referrals to providers of public mental health services and the number of requests for services. The Team is cognizant that without a parallel focus on capacity development and a realistic plan to increase such capacity, improvement of screening mechanisms will at best have little impact and at worst frustrate families and providers.

Training

As these guidelines are meant to promote more effective screening for all disorders within an agency and thereby lead to an increase in identification of, and referral for, disorders typically outside of a provider's service menu and/or target population, providers across all three divisions will be making an increased number of referrals to providers of other divisions. To decrease frustration and increase the probability of accurate referrals, it is strongly recommended that training be incorporated into any future implementation of these guidelines. Although screeners will be qualified providers within one division's definition, knowledge, expertise and/or qualifications to identify symptoms or risk factors in another division's area is not guaranteed. Although the content areas are meant to guide the screener in all three areas of problems/ deficits, cross training providers on core issues within an area would increase the likelihood of accurate screenings. Additionally, dependent upon issues of implementation, those conducting screenings may require increased knowledge in specific developmental issues for children/youth. Development of a manual that can be used as an on-going reference would assist in this and provide some level of continuity across the state and time. Additionally, as noted previously, required and improved screening mechanisms will lead to an increase in referrals for assessments to other providers and in many cases to other providers for the Department of Mental Health. It is recommended that regional or local training be conducted across division providers regarding eligibility criteria, making referrals and accessing appointments.

V. REFERENCES



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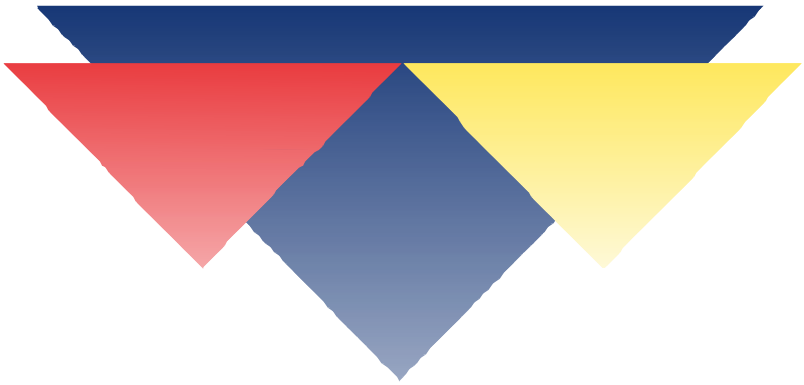
VI. APPENDICES

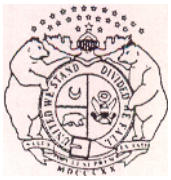


Appendix A

COMMON SCREENING TOOL ENHANCEMENTS
FOR SUBSTANCE ABUSE,

GAMBLING AND TRAUMA
PREVIOUSLY DEVELOPED FOR ADULTS

MEL CARNAHAN
GOVERNOR
ROY C. WILSON, M.D.
DIRECTOR



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June 7, 2000

Dear Colleague

As we have studied the potential development of a common screening tool, we have decided to issue enhancements to the tools that are currently being used by providers rather than develop a separate instrument to be used by all providers.

Enclosed are three lists of questions that should be incorporated into the current adult screening instruments used by providers. The following instructions should be included in the final version of the Area Plans:

1. All **ADA providers** will continue to complete the Initial Standardized Assessment Protocol (ISAP). The "Psychiatric Status Section" of the ISAP must be completed to screen for mental health issues.
2. All **ADA providers** must incorporate the enclosed Gambling Questions into the screening process.
3. All **CPS providers** must incorporate the enclosed Drug/Alcohol Use, Gambling Questions and Trauma Questions into the current screening or assessment tools.

Thank you for your patience in this matter. If you have any questions regarding the Area Planning process, please contact Gary Campbell at 573-751-9210.

Sincerely,

Michael Couty, Director
Division of Alcohol and Drug Use

Sincerely,

Dorn Schuffman, Director
Division of Comprehensive Psychiatric Services

cc Regional Administrators Internal Study Group Gary Campbell

Drug/Alcohol Use

	Past 30 Days	Lifetime Years	Oral	Nasal	Smoking	Non IV Injection	IV Injection
1. Alcohol – Any use at all			0	0	0	0	0
2. Alcohol – To			0	0	0	0	0
3. Intoxication Heroin			0	0	0	0	0
4. Methadone			0	0	0	0	0
5. Other opiates / analgesics			0	0	0	0	0
6. Barbiturates			0	0	0	0	0
7. Other sedatives / hypnotics / tranquilizers			0	0	0	0	0
8. Cocaine			0	0	0	0	0
9. Amphetamines			0	0	0	0	0
10. Cannabis			0	0	0	0	0
11. Hallucinogens			0	0	0	0	0
12. Inhalants			0	0	0	0	0
13. More than one substance per day (including Alcohol)			0	0	0	0	0

14. Which substance above is the major problem? (When not clear, ask client)

15. How long was your last period of voluntary abstinence from this problem?

16. How many months ago did this abstinence end?

17. How many times have you Had alcohol d.t.'s?

Overdosed on drugs?

18. How many times in your life have you been treated for alcohol abuse?

drug abuse?

I 9. How many of these detox only? Alcohol?

Drug?

20. How much would you say you spent during the past 30 days on alcohol?

on drugs?

21. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (include NA, AA)?

22. How many days in the past 30 have you experienced alcohol problems?

drug problems?

Gambling Questions

1.	Have you ever felt the need to bet more and more money?	Yes	No
2.	Have you ever had to lie to people important to you about how much you gamble?	Yes	No

(A yes to either question indicates a problem.)

Trauma Questions

Mother

Father

Brothers / Sisters

Sexual partner / spouse

Children

Other family members

Close friends

Neighbors

Co-workers

		Past 30 Days		In Your Life	
		Yes	No	Yes	No
I	Did any of the people listed above abuse you during the past 30 days or in your life?	0	0	0	0
	A. Emotionally? (make you feel bad through harsh words)	0	0	0	0
	B. Physically? (cause you physical harm)	0	0	0	0
	A. Sexually? (force sexual advances or acts)	0	0	0	0

Appendix B

CURRENT SCREENING PRACTICES
AMONG DMH TREATMENT PROVIDERS

I ADA Division Treatment Provided Screening Practices for Developmental Disabilities and Mental Illness

A Children involved through their mothers enrollment in women's CSTAR.

Beginning in 2000, ADA Division recommended adoption of the CSTAR's Children Screening Form that was developed by their women's CSTAR providers for use with all children coming to services through their mother's enrollment in a woman's CSTAR program (see attachment 1). It is age specific being designed for use through the end of the fourth grade approximately age 10. It includes a detailed review of developmental milestones and school performance that would adequately screen for developmental disabilities and includes detailed questions about major symptoms of mental illness as they present in children. Overall, it appears to meet the recommendations of the Practice Guideline Research Writing Team. A survey of each woman's CSTAR program individually found this form had been adopted by all except one (Family Counseling Center, Kennett), which was using their own form that covered the same areas. Overall children seen through women's CSTAR programs are currently being screened for mental illness and developmental disabilities in a manner consistent with the guideline recommendations.

B Adolescents in Treatment at adolescent CSTAR Programs.

ADA Division, since 2000, has mandated use of the Missouri Adolescent Comprehensive Substance Assessment. Items related to developmental disability include grade level and performance, repeated/failed grades, learning disabilities, if they have an IEP, literacy program involvement, trouble with comprehending, concentrating and remembering. However, it does not contain an inventory of developmental milestones or specific questions about developmental disability. It does not inquire about the history of receiving services for developmental disability. Regarding screening for mental illness, it covers a full range of psychiatric symptoms as they commonly present in adolescence and ask specifically about past mental health treatment, suicidal and suicidal behaviors and overall as a comprehensive screen for mental illness.

II CPS Treatment Providers Screening Practices for Substance Abuse and Developmental Disability

All twenty-two current CPS Administrative Agents were surveyed; nineteen agencies responded. There was a wide-range of variability in the extent of screening across the agencies for both mental retardation and for substance abuse. Table 1 shows summary results of the extent of screening (see below).

Table 1

Extent of Screening	MR	SA
None	7	6
Minimal	4	7
Thorough	7	5

Table 2 (see attached) shows screening practices in detail by individual agency. Overall only five agencies had adopted the substance abuse screening items previously mandated by CPS (see

Appendix I) (Research, Pathways, Swope, Tri-County and Mark Twain) and only four agencies thoroughly screen for both substance abuse and mental retardation in a manner consistent with the recommendations of the Practice Guideline (Pathways, Research, Tri-County and Swope).

III MRDD Regional Center Practices Regarding Screening for Substance Abuse and Mental Illness

Ten of eleven regional centers responded to a survey of their current screening practices. None currently survey in any manner for substance abuse, three indicate that they screen in some manner for mental illness but provided no specific form or question format. Comments indicated that they did so by "review of collateral information" or "if apparent". Overall it appeared that none of the Regional Centers currently meet the guideline recommendations for screening for the presence of mental illness or substance abuse.

SCREENING SURVEY

AGENCY	SA 1	MR 2	Provided Forms	MR Screening Details	SA Screening Details
BJC	Y	Y	A	Single question on MR * Contact Person	2 questions – 1) Ever Treated? 2) Currently using?
Clark Community MHC	Y	N	B	No specific question*	No specific question *
Comprehensive Mental Health Services	Y	Y	C	MSE references intelligence *	Initial History* Includes SA
Research Mental Health Services	Y	Y	D	Developmental milestones & education history	Items from mandated common screen
Pathways Community Behavioral Health	Y	Y	E	MSE includes intellect education history and special education summary reference developmental issues	Items from mandated common screen
Ozarks Medical Center	Y	Y	F	Developmental history and Education; intellectual ability	Addictive Behavior
North Central Mo MHC	N	N	-	Developmental history *	SA evaluation
Crider Center	Y	Y	G	Substance abuse evaluation *	Developmental history*
University Behavioral Health	Y	Y	H	Check school record but no specific questions	Asks about use and treatments
Bootheel Counseling Services	N	N	-		
Community Counseling Center	Y	Y	-		
Tri-County Mental Health	Y	Y	I	Developmental & Education history	Mandated common screening items
Mark Twain Area Counseling	Y	N	J	Nothing	Mandated common screening items
Arthur Center	Y	Y	K	CBCL, lengthy ADD checklist	None
Truman Medical Center	Y	Y	-		
Family Guidance Center	Y	Y	-	“Clinical Interview”	“Clinical Interview”
Burrell Behavioral Health	Y	Y	L	Recent Substance Abuse *	Functioning – education *
Swope Parkway Health Ctr	Y		M	Checkbox – IEP; education setting, developmental history; CBCC; BPRS	Checkbox “involvement with SA agency” full page evaluation
BJC – Park Hills	Y	N	N	CAFAS CBCC	Substance use treatment history *

Appendix C

LITERATURE REVIEW

DT: Journal-Article
TI: Guidelines for the assessment process (GAP).
AU: Fernandez-Ballesteros,-Rocio
SO: European-Psychologist. 1997 Dec; Vol 2(4): 352-355
AB: Presents an overview of current interest and involvement in psychological assessment. The work of several international organizations (e.g., the International Test Commission; the American Psychological Association) that are now working on developing principles, standards, and/or guidelines for regulating the scientific and the applied activity of the assessor is reviewed, noting that globalization requires a core of international principles that allow the evaluation of the assessment practice--from the point of view of "clients"--as well as psychological assessment teaching and training. Decisions made at the 1st Guidelines for the Assessment Process (GAP) meeting--developed by the European Association of Psychological Assessment and the Division 2 on Psychological Assessment and Evaluation of the International Association of Applied Psychology--are summarized and information on the group's working plan and planned 2nd meeting is provided. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Assessment and treatment of children and adults.
AU: Kazarian,-Shahe-S
BK: Evans, David Richard (Ed). (1997). The law, standards of practice, and ethics in the practice of psychology. (pp. 173-199). Toronto, ON, Canada: Emond Montgomery Publications, Ltd. xvi, 343 pp.SEE BOOK
AB: (from the chapter) In this chapter, the codes of conduct and ethics developed by the various governing bodies of psychology in the US and Canada are categorized into 4 main domains and discussed in the context of child and adult assessment and treatment. The 4 interrelated perspectives to the standards are (1) scientific and technical, (2) professional competence, (3) professional practice, and (4) social responsibility. The chapter is divided into 2 main sections. In the 1st section, general assessment and treatment regulations, standards and guidelines from the 4 perspectives are described. In the 2nd section, legal and ethical issues specific to child and adult assessment and treatment are discussed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Standard of care in assessment of suicidal potential.
AU: Berman,-Alan-L
SO: Psychotherapy-in-Private-Practice. 1990; Vol 8(2): 35-41
AB: Outlines the standard of care in the assessment of suicidal patients within the context of the legal system and process regarding malpractice actions. Specific guidelines for reasonable and prudent care giving are discussed. Particular reference is made to the need for contemporaneous documentation of evaluation and treatment decisions, calling attention to the clinician's need to attend to good clinical practice vs. an over concern with issues of clinical malpractice. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Chapter
TI: Evaluation of mental disorders with the PRIME-MD.
AU: Hahn,-Steven-R; Kroenke,-Kurt; Williams,-Janet-B-W; Spitzer,-Robert-L
BK: Maruish, Mark E. (Ed). (2000). Handbook of psychological assessment in primary care settings. (pp. 191-253). Mahwah, NJ, US: Lawrence Erlbaum Associates, Inc., Publishers. xiv, 848 pp.SEE BOOK
AB: (from the chapter) The Primary Care Evaluation of Mental Disorders (PRIME-MD) is a two-stage case-finding and diagnostic instrument designed specifically for use by primary care clinicians in general medical settings for the purpose of identifying mental disorders in patients. This chapter first details the development and validation history of the PRIME-MD, then follows with detailed guidelines for the administration of the test in integrated mental-primary health care service settings for diagnostic and treatment monitoring purposes. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Ethical and legal issues.
AU: Fisher,-Celia-B; Hatashita-Wong,-Michi; Greene,-Lori-Isman
BK: Silverman, Wendy K. (Ed); Ollendick, Thomas H. (Ed). (1999). Developmental issues in the clinical treatment of children. (pp. 470-486). Needham Heights, MA, US: Allyn & Bacon, Inc. xviii, 510 pp.SEE BOOK
AB: (from the chapter) This chapter examines 3 major ethical and legal challenges facing those who provide psychological services to children and adolescents: (1) protecting children's intrinsic value as persons through appropriate informed consent procedures; (2) balancing children's rights to privacy and self-governance with the obligation to protect their welfare and the welfare of others through appropriate confidentiality procedures; and (3) protecting children's right to adequate diagnoses and effective treatment through the use of developmentally and

culturally valid assessment and treatment techniques. Drawing upon both practical and empirical work on child development and ethical practice, the authors also present a broad framework of "best practices" for each of these ethical challenges in the hopes that these suggestions will contribute to the ethical decision making of mental health professionals. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Screening adolescents for health risks using interactive voice response technology: An evaluation.
AU: Alemagno,-Sonia; Frank,-Scott; Mosavel,-Maghboeba
SO: Computers-in-Human-Services. 1998; Vol 15(4): 27-37
*LHM: "Cancelled, have 1985-1993"
AB: Presents an evaluation of an interactive voice response telecommunications system developed for adolescent health risk screening. The technology provides a means to screen adolescents for general health risks and to score self-reported risk immediately. Adolescents listen to a series of prerecorded risk questions on standard touch-tone telephones and respond by pressing the appropriate keys on the keypad. Health care workers are provided immediate feedback in the form of a summary fax report. The fax report indicates the adolescent's risk level and suggested interventions. This paper reports on an evaluation of this technology to collect self-reported risk data for 116 adolescents (aged 11-18 yrs) seen in an urban family practice center in Cleveland, Ohio. Clinical impressions of the new technology in terms of accuracy, potential advantages and disadvantages to patients, providers and the practice are reported for a pilot cohort of 22 physicians. The authors examine the process of using this technology to implement screening guidelines in various settings. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Emergency psychiatry: Assessment of suicide risk.
AU: Thienhaus,-Ole-J; Piasecki,-Melissa
SO: Psychiatric-Services. 1997 Mar; Vol 48(3): 293-294
AB: Presents guidelines for psychiatrists for assessment of patients who present with suicidal ideation. It is suggested that these guidelines can help clinicians conceptualize the task of risk assessment and can serve as a reminder about areas to cover during the actual assessment. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Guidelines for developing screening programs.
AU: Rafoth,-Mary-Ann
SO: Psychology-in-the-Schools. 1997 Apr; Vol 34(2): 129-142
*LHM: Title is owned by this library
AB: Describes guidelines for designing appropriate screening programs tor children at school entrance. Six guidelines are proposed: choosing appropriate goals, matching assessment choices to program goals, using psychometrically sound instruments, incorporating findings of research into screening programs, including input from parents and other caregivers and naturalistic observation, and assuring appropriate follow-up assessment is mandated and program evaluation occurs. Each guideline is discussed with attention given to avoiding the pitfalls of inappropriate screenings, which can lead to poor decision-making. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Computer-administered clinical rating scales: A review.
AU: Kobak,-Kenneth-A; Greist,-John-H; Jefferson,-James-W; Katzelnick,-David-J
SO: Psychopharmacology. 1996 Oct; Vol 127(4): 291-301
AB: Reviews the empirical data on the reliability, validity, and equivalence of computer-administered symptom rating scales. Computer-administered versions of clinician-administered scales are available for the assessment of depression, anxiety, obsessive-compulsive disorder, and social phobia. Validation studies support the reliability, validity, and equivalence of these scales. Patient reaction has been positive, with patients generally more honest with and often preferring the computer for assessing sensitive areas such as suicide, alcohol or drug abuse, sexual behavior, or HIV related symptoms. Applications using interactive voice response (IVR) technology facilitate longitudinal monitoring of patients without requiring office visits to collect data. IVR applications also increase the accessibility of information to the clinician, and thus the quality of patient care through more informed decision making. When used in accordance with established ethical guidelines, computers offer reliable, inexpensive, accessible, and time-efficient means of assessing psychiatric symptoms. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

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DT: Journal-Article
TI: A five-minute psychiatric screening interview.
AU: Zimmerman,-Mark
SO: Journal-of-Family-Practice. 1993 Nov; Vol 37(5): 479-482
AB: Describes 3 forms of efforts to increase primary care physicians' awareness of and knowledge about psychiatric disorders: increased coverage of psychopathology in medical journals, the development of self-administered screening questionnaires, and the development of educational programs for trainees in family practice and internal medicine. Guidelines for assisting clinicians in evaluating psychiatric disorders are noted, and an example of a psychiatric screening interview that covers 15 areas of psychopathology and takes less than 5 min to complete is presented. This screening tool can effectively identify patients who require further evaluation. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Chapter
TI: Assessment of psychopathology in persons with mental retardation.
AU: Reiss,-Steven
BK: Matson, Johnny L. (Ed); Barrett, Rowland P. (Ed). (1993). Psychopathology in the mentally retarded (2nd ed.). (pp. 17-40). Needham Heights, MA, US: Allyn & Bacon, Inc. xii, 275 pp.SEE BOOK
AB: (from the chapter) begins with a consideration of three implications of the concept of dual diagnosis / one . . . is that clinicians need to provide services for all significant handicaps a person has [without labeling them as primary and secondary] / a second implication is the need to assess when maladaptive behavior is associated with psychopathology / a third implication is that clinicians should assess the full range of psychopathology / [examines] research relevant to the assessment of dual diagnosis / [discusses] some of the scientific issues addressed in the development of [dual diagnosis] measures /// guidelines for diagnosing psychopathology in persons with mental retardation / PIMRA [Psychopathology Instrument for Mentally Retarded Adults] (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Assessment and evaluation in early intervention.
AU: McLean,-Mary; McCormick,-Katherine
BK: Brown, Wesley (Ed); Thurman, S. Kenneth (Ed); et-al. (1993). Family-centered early intervention with infants and toddlers: Innovative cross-disciplinary approaches. (pp. 43-79). Baltimore, MD, US: Paul H. Brookes Publishing Co. xiii, 340 pp.SEE BOOK
AB: (from the chapter) covers the specific regulations and definitions included in PL 99-457, the original legislation that provided for early intervention services, and in PL 102-119 . . ., the most recent legislation pertaining to the identification, evaluation, and assessment of infants and toddlers with disabilities and their families /// special considerations in the assessment of infants and toddlers / guidelines for assessment / eligibility and screening / areas of evaluation / assessment of family characteristics and priorities (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Best practices in the assessment of adaptive behavior.
AU: Demchak,-MaryAnn; Drinkwater,-Sarah
BK: Vance, H. Booney (Ed). (1993). Best practices in assessment for school and clinical settings. (pp. 365-398). Brandon, VT, US: Clinical Psychology Publishing Co, Inc. x, 555 pp.SEE BOOK
AB: (from the chapter) adaptive behavior refers to the ability of an individual to meet the demands of the everyday environment and encompasses self-sufficiency as well as social competence / in recent years, the importance of adaptive behavior in assessment and program planning has increased due to stringent assessment mandates of PL [Public Law] 94-142 and a stronger emphasis on the adaptive behavior component in the definition of mental retardation / because adaptive behavior is distinct from intelligence and academic ability . . . , assessment of adaptive behavior provides unique information to the multidisciplinary assessment process / this unique information contributes to both

classification of and instructional programming for individuals with disabilities (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Patient screening and inclusion criteria.
AU: Morris,-Robin-D; Thompson,-Nancy-J
BK: Mohr, Erich (Ed); Brouwers, Pim (Ed). (1991). Handbook of clinical trials: The neurobehavioral approach. (pp. 29-44). Lisse, Netherlands: Swets & Zeitlinger. 386 pp.SEE BOOK
AB: (from the chapter) although the concept of screening has different meanings for different researchers, its main purpose is to increase the probability of obtaining the subject sample of interest for research purposes with the minimum of time, effort, cost, and error / the screening process is conceptually simple: one decides on inclusion and exclusion criteria for a specific study sample, and chooses measures which easily assess each criterion /// as with all assessment procedures though, . . . there is systematic and unsystematic error which must be considered which will affect the accuracy of the results / because of these errors, the classification or placement of patients into a specific group, or not into a specific group, cannot be 100 percent accurate / thus, clear guidelines maximizing both the descriptive and classification accuracy of neuropsychological screening procedures are imperative in the development of a sound clinical trial /// purpose of patient screening [definitions and functions of screening, screening in clinical trials, first step in hierarchical assessment process] / selection of the study group [ensuring representativeness of the sample, contribution of screening to sample size considerations] / the screening base-where does the sample come from [medical reports/records] /// screening instruments [how to choose a screening instrument, relationship of the screening instrument(s) to the instrument(s) for measuring outcome, specific concerns with the use of neuropsychological instruments for screening] / development of inclusion and exclusion criteria (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: A guide to the assessment of psychiatric symptoms in the addictions treatment setting.
AU: Woolf-Reeve,-Barbara-S
SO: Journal-of-Chemical-Dependency-Treatment. 1990; Vol 3(2): 71-96
AB: Presents a decision tree model with guidelines focused on current symptoms to assess psychiatric and behavioral symptoms in substance abusing patients. Discussion emphasizes the need to evaluate potential violence, the risk of medical danger, and the symptoms of cognitive and perceptual disorders. Treatment options are explored for patients with symptoms that interfere with substance abuse treatment. Clinical vignettes illustrate the material presented. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Screening CMHC outpatients for physical illness.
AU: Bartsch,-David-A; Shern,-David-L; Feinberg,-Lawrence-E; Fuller,-Barbara-B; et-al
SO: Hospital-and-Community-Psychiatry. 1990 Jul; Vol 41(7): 786-790
*LHM: Title is owned by this library
AB: Assessed the prevalence of physical disorders among 175 outpatients (average age 38 yrs) treated in 2 community mental health centers (CMHCs) within the public mental health system. Of these Ss, 46% had physical conditions or laboratory test results warranting further medical evaluation. An undiagnosed physical health problem was identified in 20% of the screened Ss, and about 16% had conditions that could cause or exacerbate their mental disorder. Public mental health systems should ensure routine assessment of the physical health of psychiatric outpatients and suggest guidelines for developing medical screening procedures in public settings. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Interpreting evidence of predictive validity for developmental screening tests.
AU: Miller,-Lucy-J; Lemerand,-Pamela-A; Schouten,-Peter-G
SO: Occupational-Therapy-Journal-of-Research. 1990 Mar-Apr; Vol 10(2): 74-86
AB: Reviews issues related to correlational and classificational analyses, which are used to establish validity for developmental screening instruments that identify developmental handicaps and risks. Factors that influence correlational and classification data include sampling, artificiality, length of prediction interval, lack of consensus on practical guidelines for evaluating and comparing critical values, and predictor and criterion reliabilities. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

TI: Two best-practice guidelines focus on assessment and treatment of adolescents at risk for substance abuse [news]
SO: Psychiatr-Serv. 1999 Apr; 50(4): 575-6
DT: Journal-Article

TI: Behavior Profile of a psychiatric screening instrument for Jamaican children aged 6-11.
AU: Lambert,-Michael-Canute; Knight,-Frank-H; Costigan,-Catherine-L
SO: International-Journal-of-Intercultural-Relations. 1994 Fal; Vol 18(4): 507-519
AB: Developed a screening instrument for child behavioral and emotional problems that was designed for and standardized on 160 Jamaican children aged 6-11 yrs. Teacher-reported child problem behavior is scored on 2 empirically derived syndromes (over- and undercontrolled) and on total problems. Scores are presented on a child problem profile. Standardization procedures including validity and reliability indices are presented. (PsycINFO Database Record © 2000 APA, all rights reserved) (unassigned)

DT: Journal-Article
TI: Principles of screening applied to psychiatric disorders.
AU: Ford,-Daniel-E
SO: General-Hospital-Psychiatry. 1988 May; Vol 10(3): 177-188
AB: Discusses how well psychiatric screening procedures fulfill criteria outlined by the World Health Organization for evaluating the utility of general medical screening efforts. Current research on the utility of screening for psychiatric disorders is reviewed, and the lack of data on the treatment of psychiatric disorders in the general medical sector is emphasized. The randomized clinical trial is offered as the best method to test the efficacy of screening by eliminating various biases outlined in the paper. Quantitative concepts such as positive predictive value and receiver operator characteristic analysis are discussed. The issue of whether early detection of psychiatric disorders is useful is discussed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

TI: Legal implications of clinical practice guidelines in emergency medicine.
AU: Rosoff-AJ
SO: Leg-Med. 1995: 1-15

DT: Journal-Article
TI: Correlations between two multidimensional anxiety scales for children.
AU: Muris,-Peter; Gadet,-Bjoern; Moulaert,-Veronique; Merckelbach,-Harald
SO: Perceptual-and-Motor-Skills. 1998 Aug; Vol 87(1): 269-270
AB: Studied the correlation between scores on 2 new anxiety questionnaires for children, the Screen for Child Anxiety Related Emotional Disorders and the Multidimensional Anxiety Scale for Children. 54 boys and 54 girls (aged 9-13 yrs) completed both tests. The correlation between the 2 tests was .72, with values for subtests ranging between .35 and .63. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Authored-Book; Book
TI: Clinical evaluations of school-aged children: A structured approach to the diagnosis of child and adolescent mental disorders (2nd ed.).
AU: Samuels,-Susan-K; Sikorsky,-Susana
AB: (from the introduction) The 1st edition of this book, published in 1990, has been revised in order to update diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). The main purpose of the book remains unchanged. Mental health professionals in schools need to communicate with a number of other professionals, such as psychiatrists and clinical psychologists involved in assessment, diagnosis, and treatment of mental disorders in children and adolescents. This book was created to bring about some uniformity in the behavioral considerations necessary for a given diagnosis. /// The book focuses on the child and adolescent syndromes described in the DSM-IV. It consists of 3 major inter-related components. One is a Checklist of 16 symptoms whose presence or absence should routinely be considered as part of the evaluation process. The 2nd is an updated and revised Comprehensive Narrative of all characteristics for each disorder, including its associated features. The 3rd is a revised Interview Form for use by mental health professionals when consulting with parents, teachers, and other school personnel. Case summaries have been included to illustrate the capacity of the book to confirm a given diagnosis and to suggest areas that could be productively explored by those working with the child. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: New developments in assessing pediatric anxiety disorders.
AU: March,-John-S; Albano,-Anne-Marie
SO: Advances-in-Clinical-Child-Psychology. 1998; Vol 20: 213-241
AB: Reviews a wide variety of currently available and investigational assessment methods and instruments that have been applied to pathological anxiety in pediatric populations. Self-report and interviewer-based instruments now provide reliable and valid ascertainment of symptoms across multiple symptom domains. These, and construct-specific instruments, reliably identify the major symptom clusters in anxious children, though further research is clearly necessary before discriminant validity can be claimed between specific anxiety disorders or between the anxiety disorders and

other internalizing and externalizing conditions. With respect to "severity," the availability of normative data and specific criteria for assessing functional impairment are strengths of some, but by no means all instruments, and much work remains to establish the clinical implications of categorical or dimensionalized ratings on available assessment tools. Finally, the development of new, empirically validated treatments is just beginning to drive the evaluation of whether newer instruments are sensitive to treatment-induced change in symptoms. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Assessment of child behavior problems: Internalizing disorders.
AU: Silverman,-Wendy-K; Serafini,-Lourdes-T
BK: Bellack, Alan S. (Ed); Hersen, Michel (Ed). (1998). Behavioral assessment: A practical handbook (4th ed.). (pp. 342-360). Needham Heights, MA, US: Allyn & Bacon, Inc. xvi, 471 pp.SEE BOOK
AB: (from the chapter) In this chapter, the concepts and methods involved in the behavioral assessment of internalizing behavior problems of children are discussed. The focus is particularly on anxiety and mood (depression) problems, as these are the problems that have received the most attention by researchers and clinicians. The general approach to assessing anxiety and mood problems involves the use of multiple informants (child, parent, teacher) and multiple methods. The methods include interviews, behavior problem checklists, self-rating scales, observational procedures, self-monitoring procedures, and psychophysiological measurement. In the subsequent sections, evaluative descriptions of these methods are presented, with emphasis on the specific functions or goals of these methods (e.g., screening, diagnosis). The utility of these methods in research and clinic settings, respectively, is also noted. The chapter concludes with a case study of a 10-yr-old girl that illustrates the major concepts and methods discussed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Use of the Modified Mini-Mental State Examination with children.
AU: Besson,-Penny-S; Labbe,-Elise-E
SO: Journal-of-Child-Neurology. 1997 Oct; Vol 12(7): 455-460
AB: Examined the validity and reliability of the modified version of the Mini-Mental State Examination (MMSE) with 4-12 yr olds in a nonclinical sample consisting of 79 normal children and a clinical sample of 20 children with medical or psychological diagnoses. Concurrent validity was assessed by comparing scores on the Modified MMSE with Wechsler Intelligence Scale for Children (WISC) and Child Behavior Checklist scores. Test-retest reliability of the Modified MMSE was also examined. Results show that test-retest reliability coefficients were positively significant. For the nonclinical sample, Modified MMSE scores were significantly and positively correlated with Verbal IQ and Child Behavior Checklist scores. Modified MMSE scores were significantly correlated with Verbal IQ scores in the total and clinical samples. Findings indicate that the Modified MMSE may prove to be a useful screening measure for children, especially in cases in which a child's impairment may interfere with other measures of functioning that require sustained attention and concentration. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Early detection of autism: Diagnostic instruments for clinicians.
AU: Gillberg,-C; Nordin,-V; Ehlers,-S
SO: European-Child-and-Adolescent-Psychiatry. 1996 Jun; Vol 5(2): 67-74
AB: Reviews screening and diagnostic instruments for autism and Asperger syndrome. These instruments are grouped according to the age of the child for which they are appropriate. While no instrument can diagnose autism in the first 12 mo of life, clues to an eventual diagnosis include minor physical anomalies, muscular hypotonia, developmental delay, and epileptic syndrome. Parental interview and behavioral observation can aid in detection at 18-24 mo. Eight instruments are described that can be used with children of preschool age and older, including the Childhood Autism Rating Scale. It is concluded that autism may be screened around age 18 mo and a diagnosis reliably be made around age 30 mo, whereas a diagnosis of Asperger syndrome is not usually suspected, screened, or made until into the child's school age. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA study.
AU: Shaffer,-David; Fisher,-Prudence; Dulcan,-Mina-K; Davies,-Mark
SO: Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry. 1996 Jul; Vol 35(7): 865-877
AB: Describes the DISC-2.3 and provides data on its performance characteristics in the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. The DISC-2.3 was administered at 4 sites to 1,285 children (aged 9-17 yrs) and their parents. 247 of these pairs were reassessed on the DISC-2.3 by a clinician interviewer 1-3 wks later. Administration time was approximately 1 hr and the interview was acceptable to more than

90% of Ss. The reliability of questions to parents assessing impairment and age of onset was generally good to acceptable for most diagnoses but was less satisfactory for the child interview. Prevalence of many disorders was reduced by requiring at least 1 positive specific impairment rating or minimum Global Assessment Scale score. The DISC-2 is a reliable and economical tool for assessing child psychopathology. Reliability of the DISC-P-2.3 is superior to that of the child DISC for most diagnoses but is least good for anxiety disorders. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Autism spectrum disorders in children with physical or mental disability or both: II. Screening aspects.
AU: Nordin,-Viviann; Gillberg,-Christopher
SO: Developmental-Medicine-and-Child-Neurology. 1996 Apr; Vol 38(4): 314-324
AB: Examined problems concerning screening and diagnosis of autism spectrum disorders in 448 2-17 yr olds with mental retardation or physical disability or both using Swedish translations of The Autism Behavior Checklist (ABC) and The Childhood Autism Rating Scale (CARS). The ABC score clearly reflected autism specific behavioral problems and other behavioral problems found in children with mental retardation. When the cut-off score used was 45 (lower than recommended by D. A. Krug et al [see record 64-11514]), children with autistic disorder without multiple other disabilities were reliably identified, with an acceptable rate of false positive cases. To prevent missing other autism spectrum disorders, all cases with several omitted items in their checklists were examined in greater detail. The CARS distinguished reasonably well between autistic disorder and other autism spectrum disorders although its limitations were not systematically investigated. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Detection of children with autism.
AU: Chung,-Man-Cheung; Smith,-Beryl; Vostanis,-Panos
SO: Educational-and-Child-Psychology. 1995; Vol 12(2): 31-36
AB: Reviews the individual and overlapping characteristics of screening measures, rating scales of symptoms, and educational evaluation instruments used in the detection of autism in preschool age children to adolescence, including the Checklist for Autism in Toddlers, Childhood Autism Rating Scale, and Psycho-educational Profile. The overlap between educational and clinical assessment for children with autism is discussed, and the importance of continuous partnership between professionals from education and the health service is described. The importance of early detection is also discussed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Development of a checklist for assessment of childhood psychopathology in the Indian setting.
AU: Kapur,-M; Barnabas,-I; Reddy,-M-V; Rozario,-J; et-al
SO: Indian-Journal-of-Clinical-Psychology. 1994 Mar; Vol 21(1): 40-52
AB: The Developmental Psychopathology Check List (DPCL) was developed as a screening tool to assess psychopathology in children. The tool covers developmental history, developmental problems, psychopathology, psychosocial factors, temperamental profile, and social supports and assets. Cluster analysis carried out on 221 child psychiatric cases (mean age 10.8 yrs) revealed 7 clusters, including emotion disorder, hyperkinesis, childhood psychoses, learning disorder, hysterical syndrome, conduct disorder, and autism. Interrater reliability exercises carried out for 25 cases by 2 independent raters showed an intraclass correlation of 0.968. A validation study using the Child Behavior Checklist showed the DPCL to have satisfactory external validity. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Negative affectivity in children: Development and validation of a self-statement questionnaire.
AU: Ronan,-Kevin-R; Kendall,-Philip-C; Rowe,-Margaret
SO: Cognitive-Therapy-and-Research. 1994 Dec; Vol 18(6): 509-528
AB: The NASSQ (Negative Affect Self-Statement Questionnaire) was developed to assess self-statements associated with negative affect in children and young adolescents. 382 7- to 15-yr-olds recalled representative self-statements, which were then administered to a sample along with a battery of measures used to identify criterion groups. Items discriminating between anxious/nonanxious and depressed/nondepressed criterion groups in separate 7- to 10- and 11- to 15-yr-old samples were identified. Each inventory was cross-validated on new samples. Anxious and depressive self-statement inventories were combined to form the NASSQ. Both the 7- to 10- and the 11- to 15-yr-old samples on the NASSQ were found to be internally reliable and temporally stable. Analyses supported concurrent and construct validity. The NASSQ was sensitive, and relatively specific, to an anxiety treatment. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Chapter
TI: Behavior checklists and rating forms.

AU: Daugherty,-Timothy-K; Shapiro,-Steven-E
BK: Ollendick, Thomas H. (Ed); King, Neville J. (Ed); et-al. (1994). International handbook of phobic and anxiety disorders in children and adolescents. Issues in clinical child psychology. (pp. 331-347). New York, NY, US: Plenum Press. xiii, 496 pp.SEE BOOK
AB: (from the chapter) review the research and clinical utility of selected behavior checklists [and rating scales] in the assessment of phobic and anxiety disorders in children / general psychometric issues are addressed first; selected instruments are then briefly reviewed /// informant variance / relationship with categorical classification systems / clinical and research application /// Child Behavior Checklist (CBCL) / Achenbach-Conners-Quay (ACQ) Behavior Checklist / Revised Behavior Problem Checklist (RBPC) / Conners Rating Scales (CRS) / Personality Inventory for Children (PIC) / case illustration [of a 12-yr-old male with acute leukemia and manifestations of anxiety] (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Self-report instruments.
AU: James,-Elizabeth-Murdoch; Reynolds,-Cecil-R; Dunbar,-Janet
BK: Ollendick, Thomas H. (Ed); King, Neville J. (Ed); et-al. (1994). International handbook of phobic and anxiety disorders in children and adolescents. Issues in clinical child psychology. (pp. 317-329). New York, NY, US: Plenum Press. xiii, 496 pp.SEE BOOK
AB: (from the chapter) [describes] 2 general types of self-report instruments [that] are used in the assessment of fear and anxiety in children and adolescents / omnibus personality scales . . . yield information about a child's overall emotional health in addition to providing a specific scale scores for anxiety / 3 omnibus personality instruments that measure anxiety as a part of personality will be discussed briefly--the Behavior Assessment System for Children (BASC), the MMPI, and the MMPI-A [for adolescents] /// [discuss the narrow-band] instruments specifically developed to measure fear and anxiety in children / the 3 self-report instruments most frequently used to assess anxiety and fear in children and adolescents are the State-Trait Anxiety Inventory for Children (STAIC), the Revised Children's Manifest Anxiety Scale (RCMAS), and the Fear Survey Schedule for Children--Revised (FSSC-R) /// other specific instruments [Generalized Anxiety Scale for Children (GASC), Test Anxiety Scale for Children (TASC) and Test Anxiety Scale for Children--Revised (TASC-R), Louisville Fear Schedule for Children (LFSC), Children's Fear Survey Schedule (CFSS), Piers-Harris Self Concept Scale (PHSCS)] / strengths and weaknesses of self-report instruments / case study [of a 12-yr-old male with panic attacks] (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Self-report instruments.
AU: James,-Elizabeth-Murdoch; Reynolds,-Cecil-R; Dunbar,-Janet
BK: Ollendick, Thomas H. (Ed); King, Neville J. (Ed); et-al. (1994). International handbook of phobic and anxiety disorders in children and adolescents. Issues in clinical child psychology. (pp. 317-329). New York, NY, US: Plenum Press. xiii, 496 pp.SEE BOOK
AB: (from the chapter) [describes] 2 general types of self-report instruments [that] are used in the assessment of fear and anxiety in children and adolescents / omnibus personality scales . . . yield information about a child's overall emotional health in addition to providing a specific scale scores for anxiety / 3 omnibus personality instruments that measure anxiety as a part of personality will be discussed briefly--the Behavior Assessment System for Children (BASC), the MMPI, and the MMPI-A [for adolescents] /// [discuss the narrow-band] instruments specifically developed to measure fear and anxiety in children / the 3 self-report instruments most frequently used to assess anxiety and fear in children and adolescents are the State-Trait Anxiety Inventory for Children (STAIC), the Revised Children's Manifest Anxiety Scale (RCMAS), and the Fear Survey Schedule for Children--Revised (FSSC-R) /// other specific instruments [Generalized Anxiety Scale for Children (GASC), Test Anxiety Scale for Children (TASC) and Test Anxiety Scale for Children--Revised (TASC-R), Louisville Fear Schedule for Children (LFSC), Children's Fear Survey Schedule (CFSS), Piers-Harris Self Concept Scale (PHSCS)] / strengths and weaknesses of self-report instruments / case study [of a 12-yr-old male with panic attacks] (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Assessing positive and negative symptoms in children and adolescents.
AU: Fields,-Joel-H; Grochowski,-Sandra; Lindenmayer,-J-P; Kay,-Stanley-R; et-al
SO: American-Journal-of-Psychiatry. 1994 Feb; Vol 151(2): 249-253
AB: The Positive and Negative Syndrome Scale for adult schizophrenia was modified through successive field trials on the basis of developmental characteristics of children and adolescents. The scale was then given to 34 inpatients with Mental Disorders-III-Revised (DSM-III-R) diagnoses of schizophrenia, psychosis not otherwise specified, schizoaffective, affective, conduct, personality, and developmental disorders. The instrument showed good interrater reliability and criterion-related validity, and successfully differentiated schizophrenic Ss from nonschizophrenic Ss. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Can autism be detected at 18 months? The needle, the haystack, and the CHAT.
AU: Baron-Cohen,-Simon; Allen,-Jane; Gillberg,-Christopher
SO: Annual-Progress-in-Child-Psychiatry-and-Child-Development. 1993 95-103
AB: (This reprinted article originally appeared in British Journal of Psychiatry, 1992, Vol 161, 839-843. The following abstract of the original article appeared in PA, Vol 80:29936.) 41 toddlers (aged 17-21 mo), who were at high genetic risk for developing autism, and 50 randomly selected toddlers (aged 17-20 mo) were screened with the Checklist for Autism in Toddlers (CHAT). More than 80% of the Ss passed on all items, and none failed on more than 1 of pretend play, protodeclarative pointing, joint-attention, social interest, and social play. Four Ss in the high-risk group failed on 2 or more of these 5 key types of behavior. At follow-up at 30 mo of age, the 4 Ss who had failed on 2 or more of these key types of behavior at 18 mo received a diagnosis of autism by 30 mo. A shorter version of the CHAT is appended. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: The Diagnostic Interview Schedule for Children--Revised version (DISC--R): I. Preparation, field testing, interrater reliability, and acceptability.
AU: Shaffer,-David; Schwab-Stone,-Mary; Fisher,-Prudence-W; Cohen,-Patricia; et-al
SO: Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry. 1993 May; Vol 32(3): 643-650
AB: Describes the history and assessment strategies used to investigate and revise the DISC, a highly structured interview form used by lay interviewers to elicit diagnostic criteria for the common psychiatric disorders of childhood and adolescence. Revision was based on clinical and community data that identified unreliable and undiscriminating items in an earlier version of the instrument (DISC-1). A field study was carried out with 74 parent-child pairs. Children were 11-17 yr old patients at child psychiatric clinics. Interrater reliability and acceptability to patients was high. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Primary care and screening instruments for mental disorders in children and adolescents.
AU: Pedreira-Massa,-J-L; Sanchez-Gimeno,-B
SO: European-Journal-of-Psychiatry. 1992 Apr-Jun; Vol 6(2): 109-120
AB: Reviews studies on the prevalence of mental disorders in childhood. Bibliographic research on screening instruments for mental disorders in children and adolescents compares child behavior scales and the checklists used most frequently in epidemiological surveys. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: A closer look at the Autism Behavior Checklist: Discriminant validity and factor structure.
AU: Wadden,-Norma-P; Bryson,-Susan-E; Rodger,-Robert-S
SO: Journal-of-Autism-and-Developmental-Disorders. 1991 Dec; Vol 21(4): 529-541
AB: Studied the psychometric properties of the Autism Behavior Checklist (ABC), a 57-item screening checklist for autism. Professionals (usually classroom teachers) completed the ABC on 67 6.8-25.9 yr old autistic and 56 5.6-17.9 yr old mentally retarded and learning-disabled children. Using the total score, the ABC accurately discriminated 91% of the children, with 87% of the autistic and 96% of the nonautistic group correctly classified. The accuracy of classification was virtually identical when only the more heavily weighted checklist items were used. A 3-factor model accounted for 32% of the total variance in the checklist. Results fail to provide empirical support for a single unidimensional scale for autism; there is little support for subdividing the checklist into 5 subscales based on symptom areas. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Patients who are parents: Approaches to screening of psychiatric disorders in the children of adult patients.
AU: Jellinek,-Michael-S; Murphy,-J-Michael
SO: Comprehensive-Mental-Health-Care. 1991 Spr; Vol 1(1): 57-68
AB: Discusses issues involved in identifying psychiatric disorders in children of adult psychiatric patients and approaches to screening. Identification procedures must be valid, reliable, practical, and meet criteria of sensitivity and specificity. One approach is a screening procedure conducted in the context of the adult patient's treatment. Three methods of screening are discussed: (1) a parental interview focusing on the child's major areas of daily functioning, (2) the Child Behavior Checklist, and (3) a pediatric symptom checklist. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: The utility of a DSM-III--R-based checklist in screening child psychiatric patients.
AU: Grayson,-Patricia; Carlson,-Gabrielle-A
SO: Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry. 1991 Jul; Vol 30(4): 669-673

AB: Used the Stony Brook Child Psychiatric Checklist (K. D. Gadow and J. Sprafkin, 1987), a parent-completed rating instrument based on the Diagnostic and Statistical Manual of Mental Disorders-III--Revised (DSM-III--R), as part of a psychiatric inpatient admission evaluation. Data were collected on 63 5-13 yr old children. Checklist endorsements were compared with the same parent's responses to the Schedule for Affective Disorders and Schizophrenia for School-age Children--Epidemiologic Version (H. Orraschel et al, 1982) for the most frequently occurring disorders. Sensitivity scores ranged from .69 to .93 and were very high for diagnoses of conduct disorder, oppositional defiant disorder, depression, and overanxious disorder. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Measurement of anxiety and depression in children and adolescents.
AU: Roberts,-Nasreen; Vargo,-Beverly; Ferguson,-H-Bruce
SO: Psychiatric-Clinics-of-North-America. 1989 Dec; Vol 12(4): 837-860
AB: Reviews rating scales, checklists, self-report measures, and structured interviews that are available to assess anxiety and depression in children and adolescents. Despite the difficulties inherent in measuring these processes (e.g., age differences in the manifestation of symptomatology), psychometric data indicate that a number of scales and interviews are useful in assessing anxiety and depressive disorders. Guidelines for choosing interviews and inventories are offered, and the importance of convergent and discriminant validity for instruments measuring anxiety and depression is stressed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: The Diagnostic Interview Schedule for Children, Adolescents, and Parents: Initial reliability and validity data.
AU: Johnson,-Sally; Barrett,-Paula-M; Dadds,-Mark-R; Fox,-Tara; Shortt,-Alison
SO: Behaviour-Change. 1999; Vol 16(3): 155-164
AB: Evaluated the psychometric properties of the Diagnostic Interview Schedule for Children, Adolescents and Parents (DISCAP; D. Holland & M. Dadds, 1995), for Mental Disorders-IV (DSM-IV) anxiety disorders in children and adolescents. Two studies were conducted to examine the reliability and validity of the DISCAP. In the first study, the DISCAP and the Youth Self Report (YSR; Achenbach, 1991c) were administered to 120 nonclinical adolescents (aged 12-14 yrs). In the second study, the DISCAP and Child Behavior Checklist (CBCL; T. M. Achenbach, 1991b) were administered to parents of 57 clinical children and adolescents (aged 6-16 yrs). Inter-rater reliability data was collected, and both concurrent and discriminant validity of the DISCAP were assessed against the YSR and CBCL. Inter-rater agreements for primary diagnoses were high, and rating scale data supported the concurrent and discriminant validity of the DISCAP diagnoses. Results suggest that the DISCAP can be used to facilitate reliable and valid diagnoses of childhood anxiety disorders. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample.
AU: Goodman,-Robert; Ford,-Tamsin; Simmons,-Helen; Gatward,-Rebecca; Meltzer,-Howart
SO: British-Journal-of-Psychiatry. 2000 Dec; Vol 177: 534-539
AB: Assessed the Strengths and Difficulties Questionnaire (SDQ) as a potential means for improving the detection of child psychiatric disorders in the community. SDQ predictions and independent psychiatric diagnoses were compared in a community sample of 7,984 children (aged 5-15 yrs) from the 1999 British Child Mental Health Survey. Results found that multi-informant (parents, teachers, older children) SDQs identified individuals with psychiatric diagnosis with a specificity of 94.6% and a sensitivity of 63.3%. The questionnaires identified over 70% of the individuals with conduct, hyperactivity, depressive and some anxiety disorders, but under 50% of individuals with specific phobias, separation anxiety, and eating disorders. Sensitivity was substantially poorer with single-informant rather than multi-informant SDQs. It is concluded that community screening programs based on multi-informant SDQs could potentially increase the detection of child psychiatric disorders, thereby improving access to effective treatments. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Identifying social/emotional and behavioral problems in infants and toddlers.
AU: Squires,-Jane-K
SO: Infant-Toddler-Intervention. 2000 Jun; Vol 10(2): 107-119
AB: Early identification of social and emotional problems in young children is critical for improving developmental outcomes. Once established, social/emotional difficulties remain stable over time and are highly resistant to change. Definitions of terms and issues involved in early identification of social/emotional competence in young children are presented in this article. Screening tools for identifying social/emotional difficulties in the birth to 3-yr-old population such as the Ages and Stages Questionnaires: Social-Emotional, Devereux Early Childhood Assessment Program, Infant/Toddler Symptom Checklist, and Temperament and Atypical Behavior Scale: Early Childhood Indicators of

Developmental Dysfunction are reviewed. Finally, recommendations are made for effective early identification and intervention systems. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Practice parameter: Screening and diagnosis of autism: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the Child Neurology Society.
AU: Filipek,-P-A; Accardo,-P-J; Ashwal,-S; Baranek,-G-T; Cook,-E-H Jr; Dawson,-G; Gordon,-B; Gravel,-J-S; Johnson,-C-P; Kallen,-R-J; Levy,-S-E; Minshew,-N-J; Ozonoff,-S; Prizant,-B-M; Rapin,-I; Rogers,-S-J; Stone,-W-L; Teplin,-S-W; Tuchman,-R-F; Volkmar,-F-R
SO: Neurology. 2000 Aug; Vol 55(4): 468-479
AB: Autism is a common disorder of childhood, affecting 1 in 500 children. Yet, it often remains unrecognized and undiagnosed until or after late preschool age because appropriate tools for routine developmental screening and screening specifically for autism have not been available. Early identification of children with autism and intensive, early intervention during the toddler and preschool years improves outcome for most young children with autism. This practice parameter reviews the available empirical evidence and gives specific recommendations for the identification of children with autism. This approach requires a dual process: (1) routine developmental surveillance and screening specifically for autism to be performed on all children to first identify those at risk for any type of atypical development, and to identify those specifically at risk for autism; and (2) to diagnose and evaluate autism, to differentiate autism from other developmental disorders. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful?
AU: Goodman,-Robert; Scott,-Stephen
SO: Journal-of-Abnormal-Child-Psychology. 1999 Feb; Vol 27(1): 17-24
AB: The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire that can be completed in 5 min by the parents or teachers of children aged 4-16 yrs; there is a self-report version for 11-16 yr olds. In this study, mothers completed the SDQ and the Child Behavior Checklist (CBCL) on 132 children (aged 4-7 yrs) drawn from psychiatric (high risk Ss) and dental clinics (low risk Ss). The predictive validity of the 2 questionnaires was examined by establishing how well each questionnaire was able to distinguish between the low- and high-risk samples. Scores from the SDQ and CBCL were highly correlated and equally able to discriminate psychiatric from dental cases. As judged against a semistructured interview, the SDQ was significantly better than the CBCL at detecting inattention and hyperactivity, and at least as good at detecting internalizing and externalizing problems. Mothers of low-risk children were twice as likely to prefer the SDQ. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden.
AU: Goodman,-Robert
SO: Journal-of-Child-Psychology-and-Psychiatry-and-Allied-Disciplines. 1999 Jul; Vol 40(5): 791-799
AB: The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire that asks about children's and teenagers' symptoms and positive attributes; the extended version also includes an impact supplement that asks if the respondent thinks the young person has a problem, and if so, enquires further about chronicity, distress, social impairment, and burden for others. Closely similar versions are completed by parents, teachers, and young people aged 11 yrs or more. The validation study involved 2 groups of 5-15 yr olds: a community sample (467 Ss) and a psychiatric clinic sample (232 Ss). The 2 groups had markedly different distributions on the measures of perceived difficulties, impact (distress plus social impairment), and burden. Impact scores were better than symptom scores at discriminating between the community and clinic samples; discrimination based on the single "Is there a problem?" item was almost as good. The SDQ burden rating correlated well with a standardized interview rating of burden. For clinicians and researchers with an interest in psychiatric caseness and the determinants of service use, the impact supplement of the extended SDQ appears to provide useful additional information without taking up much more of respondents' time. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: The development of the Children's Social Behavior Questionnaire: Preliminary data.
AU: Luteijn,-Ellen-(E-F); Jackson,-Sandy-(A-E); Volkmar,-Fred-R; Minderaa,-Ruud-B
SO: Journal-of-Autism-and-Developmental-Disorders. 1998 Dec; Vol 28(6): 559-565
AB: Describes the development of the Children's Social Behavior Questionnaire (CSBQ), designed to identify and describe the characteristics of problems associated with Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS). 181 parents of children (aged 6-12 yrs) with PDDNOS completed the CSBQ. Results were compared to those of normal children in the same age group. Preliminary findings indicate that the CSBQ is sensitive to differences between PDDNOS and normal children. The PDDNOS children experienced significantly more problems in a variety of

developmental areas. A similar picture emerged when analysis was carried out at item group level. Items with similar content were grouped into 9 item groups. The scores of PDDNOS children differed significantly from the scores of the controls on all 9 item groups. These results indicate that the problems of PDDNOS children cover a wide range of aspects of development. Findings demonstrate that the CSBQ provides a good basis for distinguishing the characteristics of PDDNOS children from those of normal children. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Early detection of social interaction problems: Development of a social interaction instrument in young children.
AU: Ghuman,-Jaswinder-Kaur; Freund,-Lisa; Reiss,-Allan; Serwint,-Janet; Folstein,-Janet
SO: Journal-of-Developmental-and-Behavioral-Pediatrics. 1998 Dec; Vol 19(6): 411-419
AB: Reports on the development of the Ghuman-Folstein Screen for Social Interaction (SSI), a parent/caregiver questionnaire designed to measure the capacity for basic social interaction skills across a variety of contexts in preschool children. The SSI was administered to 51 clinically referred children with a high probability of deficits in social interaction and 60 control Ss. The Ss were 2-5.1 yrs old, with diverse ethnic and socioeconomic backgrounds. Strong internal consistency, significant correlation for test/retest reliability, moderate correlation for interrater reliability and support for external validity of the SSI was established. The SSI scores differentiated between the clinically referred subjects and healthy control subjects and between children with pervasive developmental disorder (PDD) of the autistic type and other non-PDD developmental disorders. The SSI is a simple, efficient, reliable, and valid measure for the capacity for basic social interaction skills in children of this age range. The SSI has a potential to be useful in primary health care settings to identify children at risk who may need tracking and/or further evaluation and treatment services. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Do the Brigance Screens detect developmental and academic problems?
AU: Glascoe,-Frances-Page
SO: Diagnostique. 1997; Vol 22(2): 87-103
AB: The Brigance Screens are a series of measures designed to quickly detect developmental difficulties in children between 2 and 7 years of age. With the exception of the Kindergarten form, it is not known which score (out of a possible 100) is the best cutoff for sensitive detection while minimizing over-referrals. 408 Ss (aged 21-48 mo) were administered the appropriate Brigance Form and a criterion battery that included measures of achievement, language, adaptive behavior, and intelligence. Receiver Operating Characteristic analyses were used to locate optimal cutoff scores; between 72% and 100% of children with developmental disabilities were identified. At the same time, between 73% and 100% of children with normal development could also be correctly identified. These values approach standards for screening tests and suggest that the Brigance Screens are a valuable early detection tool, if appropriate cutoff scores are used. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Validation of the Revised Behavior Summarized Evaluation Scale.
AU: Barthelemy,-Catherine; Roux,-S; Adrien,-J-L; Hameury,-L; et-al
SO: Journal-of-Autism-and-Developmental-Disorders. 1997 Apr; Vol 27(2): 139-153
AB: The Behavioral Summarized Evaluation Scale (BSE), previously published and validated, was developed for the evaluation of the autistic behavior in developmentally disordered children. The Revised Behavior Summarized Evaluation Scale (BSE-R) completed the 20-item BSE scale with the most relevant items extracted from a similar evaluation carried out with very young children. Thus 9 items were added to the original scale concerning nonverbal communication, emotional, and perception areas. The test reliability and validity of this new scale were examined in 136 developmentally disabled Ss (aged 1-11 yrs). In addition to confirming the previously published findings concerning the first version of the BSE, new items were extracted from the BSE-R content validity study. They involve fundamental functions such as intention and imitation, which open new perspectives for a physiopathological approach to developmental disorders. The BSE-R is a useful tool for progressive recording of the evolution of patients both treated over long periods and included in short-term controlled therapeutic studies. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Parent and teacher ratings of challenging behaviour in young children with developmental disabilities.
AU: Sigafoos,-Jeff; Pittendreigh,-Nicole; Pennell,-Donna
SO: British-Journal-of-Learning-Disabilities. 1997; Vol 25(1): 13-17
AB: Parent and teacher ratings on the Aberrant Behaviour Checklist were compared to determine its reliability for assessing challenging behaviour in young children with developmental disabilities. Twenty-four boys and eight girls aged 20 to 72 months (mean age = 51 months) were assessed independently by a parent and teacher using the Aberrant Behaviour Checklist. There were no significant differences between parent and teacher ratings on any of the five

subscales. Spearman's rank correlation coefficients between parent and teacher ratings for each of the five subscales ranged from 0.50 to 0.83 (mean = 0.62). All correlations were significant ($p<0.01$). Confirmatory factor analyses generated item loadings consistent with the original factor structure of the ABC and similar component loadings for parents and teachers. These results suggest the Aberrant Behaviour Checklist can provide a reliable assessment of challenging behaviour when used by parents and teachers of young children with developmental disabilities. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(journal abstract)

DT: Journal-Article
TI: Baseline assessment.
AU: Desforges,-Martin; Lindsay,-Geoff
SO: Educational-and-Child-Psychology. 1995; Vol 12(3): 42-51
AB: Discusses legislation affecting the issue of early identification of special educational needs to provide early intervention and addresses the need for quality instruments for baseline assessment. The Infant Index (IID) was developed in an attempt to meet the aims of (1) identifying children's difficulties to influence teaching and provide appropriate interventions and (2) setting a baseline attainment at 5 yrs, against which an infant school might evaluate its influence. The IID was developed by reworking the Infant Rating Scale, using data from 16 infant schools in one local education authority. Analysis of the data yielded 4 subscales that are grouped to provide composite scores in basic skills and behavior. Interrater and test-retest reliability and face validity were good. Data from the 1,500 pupils in the standardization were analyzed to provide frequency charts for item, subscale, composite scale, and total scores. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Reliability of the KIDIES for diagnosing pervasive developmental disorder in children.
AU: Trad,-Paul-V; Shapiro,-Theodore; Hertzig,-Margaret; Bernstein,-David
SO: Acta-Paedopsychiatrica:-International-Journal-of-Child-and-Adolescent-Psychiatry. 1994 Aug; Vol 56(4): 283-289
AB: The Kiddie-Infant Descriptive Instrument for Emotional States (KIDIES) is a new instrument that seeks to achieve descriptive refinement in diagnosing children by rating 16 affective and behavioral dimensions. 24 Ss (aged 24-55 mo) with childhood pervasive developmental disorder and 18 control Ss (aged 32-47 mo) with mixed psychiatric diagnoses were rated using KIDIES and Mental Disorders-III-Revised (DSM-III-R) criteria. Diagnoses using the 2 ratings overlapped significantly, and results support the classification of developmentally disordered preschoolers with a dimensionally based rating scale. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Reliability of the KIDIES for diagnosing pervasive developmental disorder in children.
AU: Trad,-Paul-V; Shapiro,-Theodore; Hertzig,-Margaret; Bernstein,-David
SO: Acta-Paedopsychiatrica:-International-Journal-of-Child-and-Adolescent-Psychiatry. 1994 Aug; Vol 56(4): 283-289
AB: The Kiddie-Infant Descriptive Instrument for Emotional States (KIDIES) is a new instrument that seeks to achieve descriptive refinement in diagnosing children by rating 16 affective and behavioral dimensions. 24 Ss (aged 24-55 mo) with childhood pervasive developmental disorder and 18 control Ss (aged 32-47 mo) with mixed psychiatric diagnoses were rated using KIDIES and Mental Disorders-III-Revised (DSM-III-R) criteria. Diagnoses using the 2 ratings overlapped significantly, and results support the classification of developmentally disordered preschoolers with a dimensionally based rating scale. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Chapter
TI: Developmental screening for preschoolers.
AU: Kenny,-Thomas-J; Culbertson,-Jan-L
BK: Culbertson, Jan L. (Ed); Willis, Diane J. (Ed). (1993). Testing young children: A reference guide for developmental, psychoeducational, and psychosocial assessments. (pp. 73-100). Austin, TX, US: PRO-ED, Inc. x, 486 pp.SEE BOOK
AB: (from the preface) provide a discussion of the strengths and weaknesses of screening tests, an overview of common screening tests that may be used, and a model for a developmental screening program (from the chapter) screening is an important 1st step in identifying developmental & behavioral problems / 4 primary issues arise in considering developmental screening of young children / why should developmental screening be done / who should do the screening / how should the screening be done / what tools are available for the screening (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Developmental screening: Rationale, methods, and application.

AU: Glascoe,-Frances-P
SO: Infants-and-Young-Children. 1991; Vol 4(1): 1-10
AB: Conducting developmental screening with all young children is crucial; current research confirms the value of early intervention while recent state and federal laws support early detection and service expansion. This paper presents current concepts and issues in developmental screening, many of which challenge commonly held assumptions about how children learn and grow. Specific measures are discussed together with directions for instrument development. Practical issues in detecting young children with developmental problems are emphasized, and directions for training and further research are listed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Developmental screening.
AU: Belcher,-Harolyn-M-E
BK: Capute, Arnold J. (Ed); Accardo, Pasquale J. (Ed). (1991). Developmental disabilities in infancy and childhood. (pp. 113-131). Baltimore, MD, US: Paul H. Brookes Publishing Co. x, 515 pp.SEE BOOK
AB: (from the chapter) the basic principles of screening tests [for assessing developmental disabilities] are reviewed, and the more widely available screening instruments are examined /// characteristics of screening tests / screening [infant screening, developmental screening of children] (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Psychometric and clinical assessment of psychopathology in developmentally disabled children.
AU: Einfeld,-Stewart-L; Tonge,-Bruce-J
SO: Australia-and-New-Zealand-Journal-of-Developmental-Disabilities. 1991; Vol 17(2): 147-154
AB: Proposes an alternative to Diagnostic and Statistical Manual of Mental Disorders-III--Revised (DSM-III--R) classification of the behavioral and emotional problems of children with intellectual handicaps. Using the taxonometric method (items, IQ range, age range, informants, population), the Developmentally Delayed Children's Behavior Checklist was developed. Interrater reliability is high for parents and teachers. Clinical and research applications include pre-interview assessment, documentation of progress, and epidemiology studies. It is concluded that the instrument can be completed by primary carers and teachers to produce a score that corresponds with professionally administered instruments and assessments by clinicians. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Authored-Book; Book
TI: Assessment for early intervention: Best practices for professionals.
AU: Bagnato,-Stephen-J; Neisworth,-John-T
AB: (from the introduction) The mission of "Assessment for Early Intervention" is the planning and delivery of family-centered early childhood developmental intervention. /// Assessment for early intervention is not a test-based process. Early childhood assessment is a flexible, collaborative process in which teams of parents and professionals formatively revise their collective judgments and decisions about the changing developmental, educational, mental health, and medical needs of young children and their families. /// "Assessment for Early Intervention" is a book about the competencies of the psychologist as assessor and decision-maker, not about the adequacies or inadequacies of various assessment measures. In essence, the competent psychologist is a competent assessment instrument. /// As you read this guidebook, be aware of the following ten prominent themes. Assessment for early intervention: is team-based; includes parents as partners; focuses on family needs; emphasizes collaborative decision-making; is multidimensional; relies on convergent information; stresses social validity; employs informal and formal methods equally; is ecological; and, most importantly, has treatment validity--it prescribes and evaluates early intervention. (from the cover) Federal mandates embodied in P.L. 99-457 require that professionals have the expertise to provide family-centered early intervention services, particularly developmental assessment. The ultimate purpose of early childhood assessment is the planning of programs for children and their families, and this guidebook emphasizes that flexible collaboration is a means to this end. It demonstrates how teams of parents and professionals can strive to make joint decisions about current and changing treatment needs. It also stresses that the assessor's competence in decision-making is more important to the process than the qualities of various assessment instruments. With content that is immediately applicable, "Assessment for Early Intervention" moves beyond diagnosis (which is often premature) to prescribe broad interventions for improving the quality of life for the child and the family. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Who should be served? Identifying children in need of early intervention.
AU: Meisels,-Samuel-J; Wasik,-Barbara-A
BK: Meisels, Samuel J. (Ed); Shonkoff, Jack P. (Ed). (1990). Handbook of early childhood intervention. (pp. 605-632). New York, NY, US: Cambridge University Press. xxi, 760 pp.SEE BOOK
AB: (from the chapter) all of the states have begun to confront the critical issues of early identification, including such problems as how many handicapped infants and toddlers there are in the state; what the prevalence is of specific

disabling conditions in the birth to 3-year-old population; how to define the at-risk category; whether all disabled and developmentally at-risk children should receive services; when and how often at-risk children should be assessed; which valid screening and assessment instruments are available; and how developmentally vulnerable children and their families can be assessed meaningfully / this chapter will attempt to respond to these issues and problems (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Behavior classification system for children with developmental, psychiatric, and chronic medical problems.
AU: Thompson,-Robert-J; Kronenberger,-William; Curry,-John-F
SO: Journal-of-Pediatric-Psychology. 1989 Dec; Vol 14(4): 559-575
AB: Derived a behavior classification system based on Missouri Children's Behavior Checklist (MCBC) ratings. Using an accumulated MCBC data base on 471 developmentally disabled, 155 psychiatrically ill, 184 chronically ill, and 44 nonreferred control children (aged 4-14 yrs), raw scale scores were transformed into T scores and then factor analyzed. Three factors emerged: Internalizing, Externalizing, and Sociable. There were 4 behavior problem patterns: internal, external, mixed internal and external profiles, and undifferentiated disturbance. There were 3 behavior problem free patterns: low social skills, problem-free, and sociable profiles. The distribution of the 7 behavior patterns differed significantly across Ss with developmental, psychiatric, and medical problems and nonreferred controls. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Developmental screening of preschool children: An overview.
AU: Arya,-Saroj
SO: Indian-Journal-of-Disability-and-Rehabilitation. 1987 Jul-Dec; Vol 2: 7-22
AB: Provides an overview of developmental screening, the aim of which is the earliest identification of disabilities likely to have developmental implications so that appropriate measures may be taken to ameliorate or minimize the disabilities detected. A rationale of early identification and early intervention, a historical perspective, and alternative approaches to screening are provided. Methods of screening, issues in screening procedures, and screening personnel are described. Guidelines are provided for selecting and reviewing screening instruments. Some of the selected screening instruments are critically reviewed and selected on the basis of frequency of use, extent of research efforts, and quality of test construction and standardization. Tests include the Minnesota Preschool Inventory and the Vineland Social Maturity Scale. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Parent report as a means of administering the Prescreening Developmental Questionnaire: An evaluation study.
AU: Burgess,-David-B; et-al
SO: Journal-of-Developmental-and-Behavioral-Pediatrics. 1984 Aug; Vol 5(4): 195-200
AB: Assessed the ability of 3 rapid screening procedures to predict full Denver Developmental Screening Test (DDST) results. 90 children (aged 6 mo to 5 yrs) were randomly assigned to 1 of 3 prescreening groups. The 1st group was prescreened with the Prescreening Developmental Questionnaire (PDQ) administered in the standard fashion, in which the mother reads and answers 10 questions about her child's development. The 2nd group was prescreened using a modified means of administering the PDQ (PDQ--M), in which a health care professional reads each PDQ question to the mother. The 3rd group was prescreened with the Alpern-Boll Developmental Profile II, a relatively lengthy procedure utilizing parent report information. Each of the prescreening procedures was highly predictive of performance on the DDST. The Alpern-Boll profile, as anticipated, demonstrated greater validity than the PDQ and PDQ--M on 6 of 7 indices of validity, generated from a 4-group referral matrix. The 2 PDQ procedures were equivalent in their validity characteristics. The PDQ--M appears to be an acceptable means of screening preschool children for developmental delays. (16 ref) (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Substance Misuse in Adolescence Questionnaire (SMAQ): A pilot study of a screening instrument for problematic use of drugs and volatile substances in adolescents.
AU: Swadi,-Harith
SO: Child-Psychology-and-Psychiatry-Review. 1997; Vol 2(2): 63-69
AB: This paper reports pilot development and consistency and validity testing of a quick screening questionnaire, consisting of 9 simple questions, to be used in assessing adolescent substance users for problematic use. 33 adolescents (aged 12-17) served as Ss. The test's internal consistency was .83. When compared to Mental Disorders-III-Revised (DSM-III-R) criteria and to a detailed semi-structured interview, it showed acceptable levels of specificity and sensitivity. The assessment instrument is appended. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Validation of the Teen Addiction Severity Index (T-ASI): Preliminary findings.

AU: Kaminer,-Yifrah; Wagner,-Eric; Plummer,-Barry; Seifer,-Ronald
SO: American-Journal-on-Addictions. 1993 Sum; Vol 2(3): 250-254
AB: The Teen Addiction Severity Index (TASI) is a semistructured interview that was developed to fill the need for a reliable, valid, and standardized instrument for periodic evaluation of adolescent substance abuse. This study had 3 objectives: (1) to determine whether the TASI discriminated between hospitalized psychiatric patients with and without comorbid psychoactive substance use disorder; (2) to determine whether TASI scores were related to other indices of problem behavior; and, (3) to determine whether there was any specificity in the ratings of different domains of the instrument when compared with other criteria. Ss were 25 adolescents (aged 12-17 yrs) who were consecutively admitted to an inpatient psychiatric unit. Results of the study provide support for the psychometric properties of the TASI. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

DT: Journal-Article
TI: Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire.
AU: Winters,-Ken-C
SO: Addictive-Behaviors. 1992 Sep-Oct; Vol 17(5): 479-490
AB: Developed a new adolescent alcohol and other drug (AOD) abuse screening scale, the Personal Experience Screening Questionnaire (PESQ). In Stage 1, 649 Ss (aged 12-18 yrs), who participated in the study to develop the 16-item PESQ, were receiving AOD abuse evaluation in 16 Minnesota residential or outpatient drug clinic assessment programs. Ss were divided into a developmental sample of 398, used to identify the new screening items, and a replication sample of 248, used in preliminary reliability and validity evaluations. In Stage 2, reliability and validity evaluations of the PESQ were based on 1,885 normal school Ss, 611 juvenile offenders, and 186 school clinic Ss, in addition to an adjusted replication drug clinical sample of 226 Ss. The PESQ was associated with initial evidence of reliability (internal consistency) and discriminant validity. However, further research on the PESQ is needed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(unassigned)

TI: The epidemiology of substance use among middle school students: The impact of school, familial, community and individual risk factors.
AU: Abdelrahman,-A-I; Rodriguez,-Gloria; Ryan,-John-A; French,-John-F; Weinbaum,-Donald
SO: Journal-of-Child-and-Adolescent-Substance-Abuse. 1998; Vol 8(1): 55-75
AB: Examined the prevalence and correlates of substance use among a representative sample of 2,849 New Jersey 7th and 8th grade middle school students. Risk of using cigarettes, alcohol, and drugs (marijuana, cocaine, crack) was predicted in relation to vulnerability and/or risk factors. Risk factors included family history of drug or alcohol treatment, divorce or family conflict, mobility, economic deprivation, neighborhood drug use, grades, dislike of school, peer pressure, and background factors (sex, grade level, ethnicity). Results revealed considerable use of substances, especially alcohol and tobacco, and support multiple effects of community, school, family, individual, peer, and background factors on substance use. Family substance abuse treatment was a strong and consistent predictor of substance use. Families with rules against alcohol and drug use had stronger inhibiting effects on substance use than family structure or conflict. Academic failure and peer use of substances had the strongest and largest effects on substance use. There were no gender differences in smoking or alcohol use, but males were twice as likely to use drugs when all risk factors were controlled for. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: The epidemiology of drug use among American youth.
AU: Harrison,-Lana-D; Pottieger,-Anne-E
BK: McCoy, Clyde B. (Ed); Metsch, Lisa R. (Ed); et-al. (1996). Intervening with drug-involved youth. (pp. 3-22). Thousand Oaks, CA, US: Sage Publications, Inc; Thousand Oaks, CA, US: Sage Publications, Inc. xviii, 222 pp.SEE BOOK
AB: (from the chapter) the contributions of epidemiology to our understanding of drug problems . . . are measurement and analysis of (a) drug use levels and patterns, (b) correlates of drug use such as attitudes about drugs, and (c) the health-related consequences of drug use or abuse / examine drug use among youth in the US, using descriptive epidemiological prevalence and trend data from national surveys / explore some of the possible reasons for the increases and decreases in drug use among youth /// history of illicit drug use among youth / current use patterns / 20-yr trends in youth drug use / explaining the trends in youth drug use (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Acquisition of high-risk behavior by African-American, Latino, and Caucasian middle-school students.
AU: Westhoff,-Wayne-W; McDermott,-Robert-J; Harokopos,-Voula
SO: Psychological-Reports. 1996 Dec; Vol 79(3, Pt 1): 787-795

AB: The purpose of this study was to measure the stages of acquisition of selected high-risk health behaviors in 768 randomly selected 7th- and 8th-graders in a Florida school district. Specific high-risk health behaviors included use of alcohol, tobacco, and drugs, fighting and weapon carrying, and suicide ideation. Analysis indicated few behaviors that were significantly different when African-American and Latino students were compared with Caucasian students. The most weapon carrying was reported by Latinos. Fewer Caucasian students than their minority peers used inhalants. Knowledge of stages of acquisition among small diverse samples may assist school personnel to intervene during the inculcation process with appropriate responsive programs. (PsycINFO Database Record (c) 2000 APA, all rights reserved)(journal abstract)

DT: Journal-Article
TI: Applications of developmental epidemiological data linkage methodology to examine early risk for childhood disability.
AU: Redden,-Sandra-Cluett; Mulvihill,-Beverly-A; Wallander,-Jan; Hovinga,-Mary-A
SO: Developmental-Review. 2000 Sep; Vol 20(3): 319-349
AB: A fundamental problem in providing mandated early intervention services for young children at risk for disabilities is defining, identifying, and prioritizing at-risk children. Research studies using various methodologies, including longitudinal, have been employed to resolve such issues. While these studies have provided important findings, major and costly disadvantages impact their utility. A research design is needed to overcome these limitations and substantiate a method of effective early identification of children at risk for later disability. Developmental epidemiology is proposed as one such method beneficial within the field of developmental psychology. To this end, the article reviewed and discussed definitions of risk, methods for predicting risk, and the use of developmental epidemiological methods. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Chapter
TI: Epidemiology of the developmental disabilities.
AU: Lipkin,-Paul-H
BK: Capute, Arnold J. (Ed); Accardo, Pasquale J. (Ed). (1991). Developmental disabilities in infancy and childhood. (pp. 43-67). Baltimore, MD, US: Paul H. Brookes Publishing Co. x, 515 pp.SEE BOOK
AB: Presents epidemiological data on the prevalence of developmental disabilities among children. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Mental health in pediatric settings: Distribution of disorders and factors related to service use.
AU: Briggs-Gowan,-Margaret-J; Horwitz,-Sarah-McCue; Schwab-Stone,-Mary-E; Leventhal,-John-M; Leaf,-Philip-J
SO: Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry. 2000 Jul; Vol 39(7): 841-849
AB: Examined child psychiatric disorders in pediatric settings and identified factors associated with parents' use of pediatricians as resources concerning emotional/behavioral issues and use of mental health services. Ss were 1,060 5-9-yr-old's families drawn from pediatric practices. Parent interviews included assessments of psychiatric disorders with the Diagnostic Interview Schedule for Children (DISC-R), parental depression/anxiety, possible child abuse, stress, support, and the use of mental health services. The prevalence of any DISC disorder was 16.8%. Parental depression/anxiety and possible child abuse were associated independently with 2-3-times higher rates of disorder. Many parents (55%) who reported any disorder did not report discussing behavioral/emotional concerns with their pediatrician. Factors related to seeing a mental health professional were discussing behavioral/emotional issues with the pediatrician, single parenthood, and stressful life events. The prevalence rates of disorders in this setting suggest that pediatricians are well placed to identify and refer children with psychiatric disorders. However, most parents do not discuss behavioral/emotional issues with their pediatrician. Methods for improving rates of identification and referral are considered. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: "Prevalence and impact of parent-reported disabling mental health conditions among U. S. children": Comment.
AU: Costello,-E-Jane
SO: Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry. 1999 May; Vol 38(5): 610-613
AB: Comments on the article by N. Halfon and P. Newacheck (see record 1999-13939-019). Costello outlines the requirement for measuring how Halfon and Newacheck fared in their efforts to provide an estimate of the burden of child mental illnesses. She also questions the National Health Interview Survey (NHIS) method of calculating their estimates. In addition, she explains that parity for mental illness health insurers legislation needs the data as ammunition to inform the state and federal government agencies. However, Costello maintains that the real value of Halfon's article is the inclusion of information about the impact of mental illness on children's lives and the service system. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: Prevalence and impact of parent-reported disabling mental health conditions among U. S. children.
AU: Halfon,-Neal; Newacheck,-Paul-W
SO: Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry. 1999 May; Vol 38(5): 600-609
AB: Provides a current national profile of the prevalence and impact of parent-reported disabling mental health conditions in US children. 99,513 children younger than 18 years old included in the 1992-1994 National Health Interview Survey participated. The response rate exceeded 94% in each year. Disability is defined as the long-term reduction in a child's ability to perform social role activities, such as school or play, as a result of his/her mental health condition. On average, 2.1 % of U.S. children were reported to suffer from a disabling mental health condition in 1992-1994. The most common reported causes of disability include mental retardation, attention-deficit hyperactivity disorder, and learning disabilities. While national prevalence estimates were produced for some low-prevalence conditions such as autism, for many specific diagnoses the reported prevalence rates were too low for accurate national population estimates using this data set. Logistic regression analysis demonstrates that prevalence of a disabling mental health condition was higher for older children; males; children from low-income, single-parent families; and those with less education. These conditions are also associated with high rates of special education participation and health system use. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

DT: Journal-Article
TI: The prevalence of serious emotional disturbance: A re-analysis of community studies.
AU: Costello,-E-Jane; Messer,-Stephen-C; Bird,-Hector-R; Cohen,-Patricia; Reinherz,-Helen-Z
SO: Journal-of-Child-and-Family-Studies. 1998 Dec; Vol 7(4): 411-432
AB: Estimated the prevalence in the population of Serious Emotional Disturbance (SED) in children and adolescents to assist states in their task of including such estimates in their applications for Block Grant funds. Seven data sets were identified that could provide estimates of SED. Common definitions of the key components of SED and of impairment were agreed upon. A set of correlates and risk factors for SED was also defined. Data were analyzed using these standard definitions, and the proportion of SED youth who received mental health care was calculated. The median estimate of SED with global impairment was 5.4%, with a range from 4.3% to 7.4%. Estimates of SED with domain-specific impairment ranged from 5.5% to 16.9% (median 7.7%). Rates were slightly higher in boys. There were no clear ethnic differences. Poverty doubled the risk of SED. Only 1 SED child in 4 had recently received mental health care. Estimates of SED are critically dependent on the method used to define diagnosis and functional impairment. Using common definitions, 7 studies produced fairly consistent estimates, which were similar to the estimate of prevalence of Serious Mental Illness (SMI) in adults. Implications for the estimate of state-by-state prevalence rates are discussed. (PsycINFO Database Record (c) 2000 APA, all rights reserved)

From the American Academy of Child and Adolescent Psychiatry's journal the following practice parameter articles were reviewed:

Assessment of Children and Adolescents
Assessment and Treatment of Children and Adolescents … with Language and Learning Disorders… with Substance Abuse Disorders…and adults with autism and Pervasive Developmental Disorders…and adults with Mental Retardation and comorbid mental disorders

Appendix D

MISSOURI DEPARTMENT OF MENTAL HEALTH

CRITERIA FOR QUALIFIED PROFESSIONALS

Qualified Mental Health Professional

1. A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one year of experience under supervision in treating problems related to mental illness or specialized training;
2. A psychiatrist, a physician licensed under Missouri law who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association or other training program identified as equivalent by the Department of Mental Health;
3. A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services;
4. A professional counselor licensed under Missouri law to practice counseling and with specialized training in mental health services;
5. A clinical social worker licensed under Missouri law with a Master's degree in social work from an accredited program and with specialized training in mental health services;
6. A psychiatric nurse, a registered professional nurse licensed under Chapter 335 RSMo with at least two years of experience in psychiatric nursing;
7. An individual possessing a master's or doctorate degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling or family therapy or related field who has successfully completed a practicum or has one year of experience under the supervision of a mental health professional;
8. An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, has a bachelor's degree and has completed a practicum in a psychiatric setting or has one year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting or has one year of experience in a psychiatric setting;
9. An advanced practice nurse – as set forth in section 335.011 RSMo, a nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Board of Nursing; and
10. A psychiatric pharmacist as defined in 9 CSR 30-4.030.

Qualified Substance Abuse Professional

A person who demonstrates substantial knowledge and skill regarding substance abuse by being either –

1. A counselor, psychologist, social worker or physician licensed in Missouri who has at least one year of full-time experience in the treatment or rehabilitation of substance abuse;
2. A graduate of an accredited college or university with a master's degree in social work, counseling, psychology, psychiatric nursing or closely related field who has at least two years of full-time experience in the treatment or rehabilitation of substance abuse;
3. A graduate of an accredited college or university with a bachelor's degree in social work, counseling, psychology, or closely related field who has at least three years of full-time experience in the treatment or rehabilitation of substance abuse; or
4. An alcohol, drug or substance abuse counselor certified by the Missouri Substance Abuse Counselors Certification Board, Inc.

Qualified Mental Retardation Professional

1. Psychologist: A person with at least a master's degree in psychology from an accredited school and with at least one year of experience working directly with persons with mental retardation or other developmental disabilities.
2. Physician: A doctor of medicine or osteopathy who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.
3. Social Worker: A person who holds a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or a person who holds a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body. The social worker must also have at lest one year of experience in working directly with persons with mental retardation or other developmental disabilities.
4. Occupational Therapist: A person who is eligible for certification by the American Occupational Therapy Association or another comparable body and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.
5. Physical Therapist: A person who is eligible for certification by the American Physical Therapy Association or another comparable body and who has at least one year experience in working directly with persons with mental retardation or other developmental disabilities.
6. Speech Pathologist or Audiologist: A person who is eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the Speech-Language Hearing Association or another comparable body; or a person who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification. A speech pathologist or audiologist must also have at least one year of experience in working with persons with mental retardation or other developmental disabilities.
7. Registered Nurse: A person who is a registered nurse and who has at least one year of experience in working directly with persons with mental retardation or other developmental disabilities.
8. Professional Recreation Staff Member: A person who has a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education and who has at least one year of experience in working directly with persons with mental retardation or other developmental disability.
9. Human Services Professional: A person who has a least a bachelor's degree in a human services field (including but not limited to: sociology, special education)

Appendix E

SUMMARY REVIEW OF TESTS

Instrument Name	Authors	What does it assess? Subject Age	Number Items & Time needed to Complete	Who administers? Training needed & Scoring procedures	Reliability or validity Data	Other Information
Strengths and Difficulties Questionnaire (SDQ)	Goodman, R.	Detects behavioral problems (including conduct, emotional problems, inattention and hyperactivity) in 4-17 year olds	25 items in brief version.	Self- administered. There are 3 response categories: somewhat true, not true, and certainly true, which are assigned numbers 1, 0, and 2. Scores are added to find a total difficulties score.	95% confidence intervals (though this is due to small sample size). Does as well as the Rutter questionnaire & CBCL at detecting conduct and emotional problems & better than the CBCL at finding hyperactivity.	There are several versions of the SDQ, including a brief version for children's' parents or teachers, a brief self-report version, and an extended version (impact supplement) which asks parents or teachers about child's distress, social impairment, & chronicity.
Stony Brook Child Psychiatric Checklist	Gadow, K.D. and Spafkin, J. (hgrayson and Carlson article)	DSMIII_R symptoms For school age children	104 items	Parents answer as part of clinical interview 4 response categories: never, sometimes, often, very often	Sensitivity scores from .69 to .93 with Kiddie SADs and Schizophrenia Schedule Specificty lower so many false positieves Kappa's vary from .16-.76	Most helpful for high lighting symptom areas that might otherwise be missed. Uncommon disorders not satisfactorily addressed.
Negative Affect Self Statement Questionnaire (NASSQ)	Ronan, K.R., Kendall, P.C., and Rowe, M	Self-statements associated with negative affect (useful as predictor of depression). For children & adolescents ages 7-15	14 items for 1-10 year olds. 39 items for 11-15 year olds.	Anyone who can read the instrument interaction aloud to subjects. Add up responses (which subject records on scale of 1-5) to get total score	When developed, found to be internally reliable & temporally stable. Shows discriminate validity.	Children and adolescents are given different questionnaires. And while the measure may correlate with DSM, it is not meant as a diagnostic tool.
The Teen Addiction Severity Index (TASI)	Kaminer, Y.Bukstein O., & Tarter, R	Provides basic information on adolescents when first admitted to in-patient care	Takes 30-45 min. Is a semistructued interview.	Training needed on interviewing teens with substance abuse	High reliability and good overall rating agreement	

Instrument Name	Authors	Who does it assess? Ages of subjects	Number of items/ Time to complete	Who administers? Training needed Scoring	Reliability or validity data	Other Info.
Checklist of autism in Toddlers (CHAT)	Baren-Cohen, S., Allen, J., and Gillberg, C.	Used for the detection of autism in children of 18 months.	Takes 15 minutes. Includes 9 questions to parent and 5 observations by test administrator	Family doctor or other health care professional	On longitudinal studies, the CHAT was found to reliably predict autism	
The Autism Behavior Checklist (ABC)	Krug, D.A., Arick, J., & Almond, P.	Allows identification of autism in children and adults (18 months and up)	One page long- contains 30 questions.	Completed by professionals in the special ed. Field who know the subject. They circle items that describe the child; items are weighed & added. Score of about 77 / 158 indicates autism	Is successful at discriminating between autism and other diagnoses (e.g. mental retardation)	
Personal Experience Screening Questionnaire	Winters, K.	Screens for further need of assessment of drug use disorders. The scale provides a severity score & measures psychosocial problems & drug use	40 items. Takes 10 minutes to complete	Self-administered. Used by health professionals. Scoring takes 3 minutes & instructions are in booklet.		Should not be used to replace a comprehensive assessment
Kiddie PANS (Positive and Negative Syndrome Scale)	Fields, J.H., Grochowski, S., Lindenmeyer, J.P., Kay, S.R., Grosz, D., Hyman, R.B., & Alexander, G.	Measures positive and negative symptoms (as indicators of schizophrenia). Used for children and adolescents, ages 6-16 Also includes information collected from the primary caregiver.	Includes short prepatient interview with care-giver (less than 25 min.) and 25. min. patient interview with semistructured and structured sections	Administered by trained child psychiatrists	In development, found to have good internal consistency. Successfully distinguished between those with schizophrenia and those without.	

Appendix F

TESTS CITED

Autism Behavior Checklist

Krug, D.A., Arick, J.R. and Almond, P.D. (1980a) *Autism screening instrument for educational planning.* Examiner's manual, Portland, OR: ASIEP Education Company.

Krug, D.A., Arick, J.R. and Almond, P.D. (1980b) Behavior checklist for identifying severely handicapped individuals with high levels of autistic behavior. *Journal of Child Psychology and Psychiatry*, 21, 221-229.

Checklist for Autism in Toddlers

Baron-Cohen S., Allen J. and Gilberg, C. (1992) Can autism be detected at 18 months?, *British Journal of Psychiatry*, 161, 839-843.

Child Behavior Checklist

Achenbach, T.M. (1991) *Manual for Child Behavior Checklist 4-18 and 1991 Profile.* Burlington: University of Vermont, Department of Psychiatry.

Diagnostic Interview Schedule for Children

Columbia University DISC Development, NYS Psychiatric Institute, Dept. of Child and Adolescent Psychiatry, 1051 Riverside Drive, Unit 78, NY, NY 10032-1001, phone 888-814-DISC or e-mail DISC@worldnet.att.net

Negative Affect Self-Statement Questionnaire

Ronan, K.R., Kendall, P.C., Rowe, M. (1994) Negative affectivity in children: Development and validation of a self-statement questionnaire, *Cognitive Therapy and Research*, 18(6), 509-528.

Personal Experience Screening Questionnaire

Winters, K.C. (1992) Development of An Adolescent Alcohol and Other Drug Abuse Screening Scale: Personal Experience Screening Questionnaire, *Addictive Behaviors*, 17, 479-490.

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Positive and Negative Syndrome Scale for Youth (Kiddie-PANSS)

Fields, J.H., Grochoswski, S., Lindenmayer, J.P., Kay, S. R., Grosz. D., Hyman, R.B., Alexander, G. (1994) Assessing Positive and Negative Symptoms in Children and Adolescents, *American Journal of Psychiatry*, 151 (2), 249-253.

Stony Brook Child Psychiatric Checklist

Gadow, K.D. & Sprafkin, J. (1987) *Stony Brook Child Psychiatric Checklist – 3R.* Stony Brook, NY: State University of New York at Stony Brook, Department of Psychiatry.

Strengths and Difficulties Questionnaire

Goodman, R. (1997) The Strengths and Difficulties Questionnaire: A Research Note, *Journal of Child Psychology and Psychiatry*, 38, 581-586.

Goodman, R. (1999) The Extended Version of the Strengths and Difficulties Questionnaire As a Guide to Child Psychiatric Caseness and Consequent Burden, *Journal of Child Psychology and Psychiatry*, 40, 791-799.

The Teen Addiction Severity Index

Kaminer, Y., Bukstein, O., and Tarter, R. (1991) The Teen Addiction Severity Index: Rationale and Reliability, *Addictions,* 26, 219-226.

Kaminer, Y., Wagner, E., Plummer, B. and Seifer, R. (1993) Validation of the Teen Addiction Severity Index (T-ASI), *American Journal of Addictions*, 2, 250-254.

Appendix G

DESIGN OF VALIDATION STUDY

Design of validation study: Once a screening instrument has been developed, it should be validated through a comparison with a complete assessment for each problem area, age group and respondent. Although there are a number of traditional methods that are available for validating such screening instruments, the most expeditious and lowest cost methods should be selected for use. Certainly one should consider the use of full instruments/evaluations that use established criteria and procedures (e.g. Child Behavior Checklist, Diagnostic Interview Schedule for Children, or Psychiatrist ratings).

It is proposed that the George Warren School of Social Work review extant Washington University and other research programs in the U.S. doing studies of childhood mental disorders. It is expected that these studies will be on varied populations and include community-based, as well as hospital samples. We would then arrange to simultaneously administer the proposed screening instrument as an extension of one or more of these extant studies. Alternatively, we propose to develop such a program of study within the DMH. That is, the proposed screening instrument would be simultaneously administered in selected public sector programs that are currently performing full assessments in children/youth. Of course, this second approach would be complicated by the fact that most such youth programs involve clinical populations that are known to have problems, so limited information would be obtained about the potential for false positive and negatives.

Regardless of the extant studies selected for inclusion in these comparisons, DMH would support the additional costs of administering the screening instrument, data editing, data entry, and data transfer. A process would be needed in which only the relevant data from the full clinical assessments would be transferred to the validation study for analysis. This data would include child and parent demographics (age, race, gender, family situation, SES, living situation), the screener data, and the data from the established instruments.

Sample size: This program would require a minimally adequate sample for analysis of each age group and each problem area. If there were different screeners for various respondents, the sample would have to be multiplied by the number of respondent versions, with one set tested for each version. One set would include:

AGE GROUP	DEVELOPMENTAL DISABILITY	MENTAL HEALTH	SUBSTANCE ABUSE	ROW TOTALS
Preschool	50	50	X	100
Elementary	50	50	50	150
Preteen	50	50	50	150
Teen	50	50	50	150
GRAND TOTAL				**550**

Analysis of data: Data will be entered by case, with case set to indicate source of extant study. Depending on the established instrument used in the extant study, the following types of analyses will be completed:

1. Correlation between screener subscale scores and Achenbach scores relating to the same dimension.
2. T-tests on screener scores of those youth who met and didn't meet diagnostic criteria to determine a screener cutting point for the various subscales. We could use the ranges to decide on cutting point for screener based on natural cutting point or break in instrument. We could also potentially decide whether choosing a certain cut point will result in various rates of false positives and negatives. It is also possible to choose a definitive no problems and a definitive problem cutting point and then an area range that requires some judgment or further screening before sending for referral or evaluation
3. Kappa's for screener indications of problems and for established instruments indicating met diagnostic criteria (CBCL, Psychiatric ratings, DISC).

BUDGET JUSTIFICATION

BASED ON VALIDATION THAT IS DONE IN CONJUNCTION WITH EXISTING STUDIES INVOLVING FULL ASSESSMENT, A 20 MINUTE SCREENER INVOLVING ONLY ONE RESPONDENT, AND FULLY CLEANED ASSESSMENT DATA TRANSFERRED TO THE VALIDATION TEAM.

PERSONNEL

Principal Investigator TO BE NAMED. **(25% FOR 12 MOS)** $25,000.00
Responsible for the conceptualization of the project, and directing the fieldwork and statistical analyses. Meet with her staff on a weekly basis to coordinate and oversee all work.
Responsible for the daily operation of the project. This will include data analyses, supervision of staff, publications, dissemination of information and hiring.

Data Manager/ Statistical Analyst. TO BE NAMED. **(50% FTE FOR 6 MOS)** $12,000.00
Will prepare the computerized interview.
Perform and direct the data analyses.
Supervise all the data cleaning.
Direct the preparation of presentation charts and graphs.

Project Assistant. **(50% FTE FOR 6 MOS)** $ 6,000.00
Responsible for typing all drafts of the instrument.
Maintaining written communications and contact between the sites and participants.
Typing any materials needed for dissemination of information.

Interviewers, Editors $8,250.00
550 brief (20 minute) screenings will be completed, each taking approximately one hour, based on past experience, when training, time for contacting, recruiting, travel, gaining trust, editing and retrieval are included.
Interviewer salary is typically $15.00 per hour.

SUPPLIES

Research and Computer Supplies: Various research and computer supply consumables for the training, hiring, and supplying of interviewers (such as papers and pencils for fieldwork) are estimated at $500.

Photocopying: Costs for copying forms and tracing materials and drafts of the instrument are estimated at $1,000.

TRAVEL

Local travel: 100 miles at .325 cents a mile. $325.00

OTHER EXPENSES

Payment to subjects for interviews: $5.00 each. $2,750.00

Long-distance telephone: Contact with state of MO personnel and sites in other areas. $300

Postage costs: Mailing of paper interviews and forms to cooperating sites, and prepaid envelopes for their return). $1,000.

TOTAL DIRECT COSTS FOR CHEAPEST VERSION: $57,125.00, PLUS AN OVERHEAD RANGING FROM 20 TO 52%, DEPENDING ON WHO DOES THIS.
FOR EACH ADDITIONAL RESPONDENT, COSTS WILL GO UP BY ABOUT 15,000.00.
IF THE VALIDATION STUDY NEEDS TO RECRUIT SUBJECTS AND DO ITS OWN FULL ASSESSMENT, COSTS WILL TRIPLE.